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Between Ourselves

Numerically, the membership of the ***Saskatchewan Registered Nurses' Association*** places fifth in size among the provincial associations with approximately 2,300 members. Strategically, Saskatchewan has never been considered one of the possible danger zones from the Civil Defence standpoint. Thus the nurses have been more concerned with the study of the provision of reception areas for injured persons from other parts of the land. Economically, Saskatchewan is dependent on many climatic factors that may affect the crops of this largely agricultural province.

Professionally, strong leadership has forged a progressive, far-sighted organization that is ready to throw the weight of its influence behind such experimental patterns as the new central school programs that commenced operations within the past year. Less dramatic than some of the other experiments in nursing education developed in the immediate post-war period, the basically sound elements in their structure presage a long future for these schools.

Presiding over the destinies of the provincial association this year is **Grace A. Motta,** a native of Moose Jaw, who graduated from the school of nursing of the Winnipeg General Hospital and received her certificate in teaching and supervision from the University of Toronto. For the past ten years Miss Motta has been director of nursing at Moose Jaw Union Hospital. Her presidential address at the 1953 convention of the S.R.N.A. was a call to *all* the nurses in the province — not just those in executive positions — to demonstrate their right to be called truly professional. In a somewhat abridged form, this address is presented here as our guest editorial.

* * *

We have been gratified to learn, from the directors of some of the nursing services noted in our August editorial, of the response from many nurses who have expressed their interest in working in some of the more ***remote areas of our country.*** Talking recently to several new graduates whose predominant urge at the moment appears to be to travel, we emphasized again the fact that enrolment in these various nursing services is an excellent way to see new and off-the-usual-routes parts of Canada. There is only one drawback in having these attractive, wideawake, young nurses going into these more distant areas. There seems to be such a large number of personable bachelors there!

* * *

We commend, especially to those nurses who are themselves in contact with young children or who work closely with the mothers of these small fry, the description of the ***new container for pills*** and other substances, hurtful to youngsters, written by **Claire Halliday.** We decided to test the manufacturer's claim that children under five could not open the container so invited a youthful neighbor, who is exceedingly dextrous for a four-year-old, to experiment. His chagrin and bafflement were the only proof we needed of the value of the "Kidipruf."

* * *

This month we bring you the paper presented by ***Gladys J. Sharpe*** at the Congress of the International Council of Nurses dealing with ***New Trends in Curricula for Schools of Nursing.*** At the same session Miss Julieta V. Sotejo, dean of the College of Nursing, University of Philippines, and president of the Filipino Nurses' Association, presented a paper bearing the identical title. As you read Miss Sharpe's paper this month and Miss Sotejo's in December bear in mind some of the pertinent points that were brought out in the subsequent discussion:

1. With all the new trends in nursing education, we must never lose sight of the important fact that nurses must be *soundly prepared to nurse.*
2. Nurses must *want* changes in time-honored patterns of nursing education before they will join in a concerted effort to move it from where it is now to where many of us would like it to be — under the egis of the university.
3. Changes must be made throughout the whole program so that it does not become lopsided. At the end of 28 months the students' skill and judgment are still likely to be weak despite the fact she has completed all of the theoretical instruction. She cannot develop full skills without constant supervision over a longer period of time.

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Edited by DEAN F. N. HUGHES

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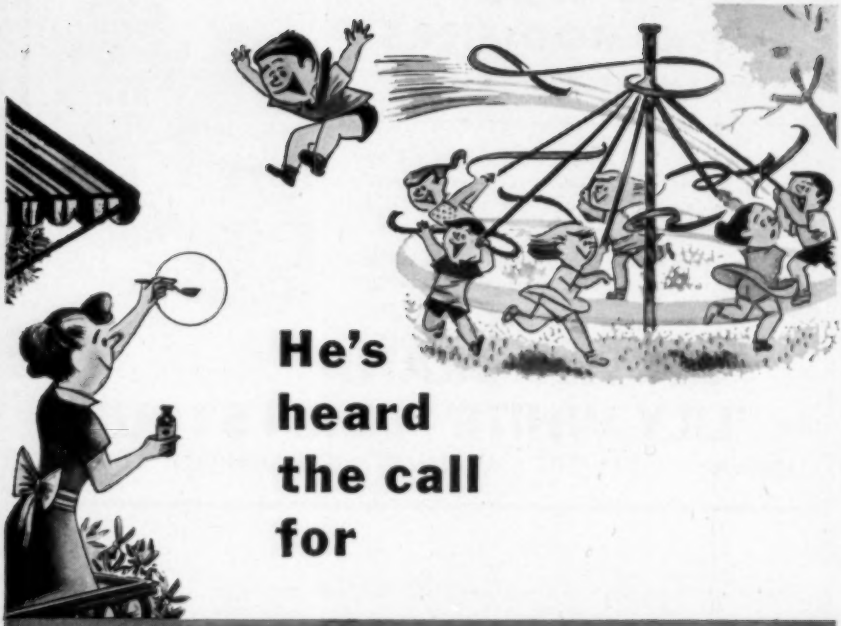

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The True Password

IT IS INTERESTING TO WATCH nursing grow toward providing more and better nursing service for all the people. The quality of tomorrow's nursing service depends upon the quality of nursing care learned in the school of nursing today. This places a serious responsibility on the nursing profession, on schools of nursing, and on the individual nurse choosing the specific area in nursing where she feels she can make the greatest contribution.

Nurse education has changed, is changing, and will continue to change. This is necessary because of continuous changes in emphasis. Much work previously done by doctors is now being done by nurses; scientific advances have added to our knowledge but have also brought about an increased awareness on the part of the public as to the need for better health practices. All this means an increase in the demands made on nurses, including the need for more medical knowledge and a greater understanding of the social, economic, and psychological needs of the patient. The future of the nursing profession, therefore, depends upon our ability to improve the quality of care we give to our patients, and to include in this care the teaching of them and their families. Each nurse must be a health teacher with the ability to teach by precept and example in order to meet the needs of the individual patient.

Nursing has for years been classed by many as a profession but we know that it is not universally accepted as such. Let us look at the meaning of the

GRACE MOTTA

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term "profession." According to the authoritative definition stated by Gowin, Wheatley and Brewer, "A profession is an occupation which has a long continued and rather definite preparation, represented usually by college and technical education, and has developed a standard of good conduct, basing its work on the service idea rather than on money." In order to be termed a professional person we would expect to find some degree of ability and competence over and above that brought to the job by people with perhaps a great deal of common knowledge but not definite training.

In speaking of "nursing," I believe we can confidently say that as a group we are a profession. However, a group is composed of individuals and is judged by individual actions. Therefore, unless we can say that every member is personally willing to accept responsibility, interested to continue to study, holds definite social aims, and takes an active part in our organization we may continue to question in our own minds and to encounter frequent questions from outside the nursing group, as to whether we are truly a profession.

Genevieve Knight Bixler and Roy White Bixler have said, "More than any other single factor, the low level of educational preparation prevents nursing today from being a real profession." Here specific reference is being made to the fact that a large percentage of student nurses spend three years in the care of sick people with the whole weight of the three years' program on service rather than on sound nursing education. The recognition by nurses of this well known picture has brought about a growing realization of the need to differentiate between the professional nurse and the less highly skilled worker. According to the Bixlers, "this is an inevitable part of the evolution of nursing towards full professional status." The professional nurse is assuming an increasingly large number of responsible duties requiring highly specialized preparation. The need for higher education for nurses will become more urgent as this evolution progresses.

It is a challenge to the nursing profession to see that nursing education of the future is placed upon a sound educational and economic basis. Its purpose must always be the improvement of nursing. Learning and experience must be based upon the educational needs of the student and not upon the needs of the hospital for nursing service.

There must be a vitalization of all our members. The spirit of professional pride, achievement, and the desire to reach higher goals mean more than just material support and integrity of intellect — they demand a willingness to make sacrifices, perhaps to give up personal cherished dreams in order that the good of the whole profession may be promoted. In his "Survey of Nursing Education in Canada" Dr. Weir said, ". . . Self-denial, if necessary, for the welfare of the whole constitutes the true password and sign of fidelity admitting to the inner sanctuary of true professional status."

Is nursing a profession? For the group the answer is undoubtedly "yes." For you as an individual, the criteria of a profession must be studied, and evaluated honestly in relation to yourself.

GRACE MOTTA
President
Saskatchewan Registered Nurses' Association

One may go wrong in many ways, but right only in one, which is why it is easy to fail and difficult to succeed — easy to miss the target and difficult to hit it.

— ARISTOTLE

In a traffic snarl one of the inevitable horn-tooters began blasting his horn. A man in a car alongside looked over and politely enquired: "What else did you get for Christmas?"

Injuries due to Cold, Frostbite, Immersion Foot and Hypothermia

D. R. Webster, M.D. *and* W. G. Bigelow, M.D.

Injuries from cold have played a major rôle in many military campaigns. History has many examples of the bitter price paid by those who entered these campaigns unprepared or were overtaken by winter with insufficient clothing, food and warmth. It requires little imagination to visualize the effects of an attack on one of our large cities in mid winter. The injuries of those lying exposed to the elements in sub-zero weather, awaiting rescue, would be vastly complicated by general chilling and actual frostbite in vulnerable or exposed portions of the body. Even the uninjured, forced into the open insufficiently clad, would soon become casualties if shelter was not readily available. If a community suffered an atomic bomb blast, the large number of casualties and sufferings inevitably inflicted would be dreadfully augmented by the effects of cold, snow and ice, and the interruption of supplies of gas, oil, electricity and other essential services. As with other injuries, proper preparation will help reduce the incidence. Stores of warm clothing, blankets and auxiliary heating units should be available in as many homes and buildings as possible. Rescue teams should be well organized to speedily remove the injured and shelter the homeless.

Physiology and Pathology

The result of exposure of a limb to cold depends on several factors. These are: the degree of cold; the duration of the exposure; amount of moisture; and the resistance of the individual. This latter factor may be modified by the state of nutrition, physical fatigue, peripheral vascular disease, or by the possession of some poorly understood substances such as cold agglutinins that would increase the susceptibility to cold injuries.

When an extremity is exposed to severe cold, vasoconstriction occurs, evidenced by blanching of the skin. This may be followed by a bright pink color due to vasodilation and lack of dissociation of oxyhemoglobin. Vasoconstriction then occurs and is permanent in the chilled state. All of the vascular tree is involved, even to the major vessels. This appears to be a protective mechanism to conserve body heat but it is at the expense of the exposed limb. The phenomenon of supercooling may prevent solidification until the temperature is considerably below that of the normal freezing point. As the temperature falls, the chilled or supercooled tissue becomes solidified although brittleness is not evident in the ordinary clinical cases. There may be injury from anoxia due to the vasoconstriction and actual damage to the cells from the freezing process. The anoxic state is augmented by capillary stasis, especially as seen in chilled limbs without actual freezing where there is escape of the plasma, leaving the red blood cells in a state of "silting" or "sludging." In frozen tissue considerable damage may be caused by the formation of ice crystals that continue to grow, disrupting the cells. This is not so evident in "quick freezing" as in a slower process. The thawing process is followed by a marked inflammatory reaction. It resembles the "triple response" to histamine. The reaction might be due to the liberation of histamine-like products from the cellular injury. Thawing occurs either from without, in, or along the course of the vessels as circulation is reestablished. Edema

The authors are on the staff of the Experimental Surgical Laboratories, McGill University, Montreal. This article is the sixth of a series to be reprinted, with permission, from the special issue for Civil Defence, published by the *Canadian Medical Association Journal*.

soon forms with escape of plasma through the damaged capillary walls. Vesicles may form, especially on the dorsum of the foot, but are rare on the face. This usually reaches its maximum in 48 hours. Stasis in the capillaries is apparently due to simple loss of plasma, possibly to the action of cold agglutinins or abnormal adhesiveness of the red blood cells. The surface temperature of the part is raised considerably, probably due to the opening of arteriovenous channels. These channels may rob the injured part of adequate circulation as gangrene will sometimes develop in a part apparently well supplied with blood. As the edema increases, areas of cyanosis may appear and there is always danger of infection in the devitalized areas.

Many terms have been used to describe the syndrome produced by exposure to cold such as frostbite, immersion foot, trench foot, chilblains, etc. The general effect of cold on the human body is commonly called *hypothermia.*

Treatment of Hypothermia

Introduction: It is conceivable that an atomic bomb attack upon a large city during very cold weather would produce casualties suffering from hypothermia or dangerous reduction in body temperature. With a very large area suddenly involved, an injured person may be forced to lie exposed to the cold for long enough to suffer a serious fall in body temperature before evacuation.

The problem: Persons rendered unconscious or suffering from true oligemic shock such as in hemorrhage, lose the protection of their heat regulating mechanism and are likely to experience an immediate and continued fall in body temperature on exposure. Persons immobilized by extensive wounds and lying exposed to the cold will likely maintain their body temperature for several hours but, being unable to move about and lying in contact with a cold and perhaps moist surface, they will eventually experience a fall in body temperature and similarly become hypothermic casualties.

Under such conditions the body temperature will fall at about 5 to 18° F. per hour (depending on the environmental temperature) for an average adult and more rapidly for small individuals and children. As body temperature falls and respiration becomes slower, heart rate and blood pressure fall. The casualty will become increasingly stuporous and at a body temperature around 82° F. one may expect complete loss of consciousness. As the body temperature falls below 82° F. respiration will become very shallow and slow and will eventually cease. Some time following that, cardiac death will follow.

It is possible to revive hypothermic victims from body temperatures as low as 65° F. In the lower range of temperatures after loss of consciousness it may be very difficult to determine whether or not the individual is dead. With minimal or absent respirations the heart may still be beating slowly. Due to the reduced blood pressure it may be impossible by palpation and auscultation to determine this and he may be mistaken for dead. This natural error is periodically reported in civil life.

The majority of cases will very likely be suffering from a milder degree of hypothermia with no noticeable effect upon their consciousness and respirations. One may expect to find frostbite of the extremities in most cases of general hypothermia.

First aid in the disaster area: No specific first aid measures are recommended to the casualty collecting units other than evacuation to the first aid post. Mild degrees of hypothermia will likely not be recognized by the C.C.U. personnel. In very cold weather, during the collection of casualties who have received their injury several hours before, the C.C.U's. should be prepared to recognize cases of severe hypothermia as described above.

First aid station: The chief duty of personnel at this level is to recognize when a casualty is suffering from hypothermia by observing the rectal temperature with a thermometer possessing a lower range than the ordinary clinical thermometer. Rewarming should be carried out with warm

blankets in a warm room. Cases of severe hypothermia, below 85° F., will require oxygen, perhaps artificial respiration if their color is blue, and evacuation to an Emergency Hospital. This is important and if respiratory depression is marked, positive pressure oxygen would be the ideal therapy.

If hypothermia cases are being admitted, the first aid station is warned not to interpret the reduced blood pressure of hypothermia, as due to hemorrhage or traumatic shock. Unnecessary blood transfusion may overload the heart.

Emergency hospitals: The method of rewarming will be the same as for the first aid station. Respiration rate, blood pressure, and rectal temperature should be charted periodically. Severe cases in which it is difficult to obtain the pulse or hear the heart beat, may best be followed with an electrocardiograph. Here again positive pressure oxygen therapy is indicated. It would be wise not to pronounce such a casualty as dead without electrocardiographic evidence.

Cardiac arrest may occur. This will take the form of ventricular fibrillation; defibrillation or electrical stimulation of the heart may be required and used if the equipment is available.

Cardiac stimulants will not be of much value. The chief therapeutic measure is to ensure full oxygenation of the blood. Sedatives should be used *sparingly* in hypothermic casualties, particularly (and preferably not at all) if they depress respirations.

A radio-frequency technique for restoring the body temperature to normal has recently been developed by the Defence Research Board and the National Research Council. This involves placing the patient between two large padded electrical coils. It is in the experimental stage at present but may be available for resuscitation purposes.

Surgical operations may be performed upon patients with a body temperature over 80° F., if necessary, provided minimal anesthetic is used and positive pressure oxygen maintained. Once again, care must be taken not to restore the blood volume above normal by excess transfusion of blood, blood substitutes or crystalloids when hypothermia and traumatic shock coexist.

Frostbite

This term is used to describe the condition resulting from exposure to cold of sufficient severity and duration to produce ice in the affected parts. In frostbite there is early vasoconstriction that can be relieved occasionally by vigorous rubbing as is often seen in the ears. This will frequently prevent further injury as the resultant hyperemia will enable the tissues to maintain an adequate temperature. When the defences are overcome, freezing occurs. Anesthesia is limited to the frozen area, thus differing from immersion foot, and edema does not occur until the part is thawed. The sequence of events is then similar to that of injury due to chilling or wet cold. Frostbite injury is usually divided into four degrees:

1. Reddening which may be followed by desquamation.
2. Vesication.
3. Destruction of the true skin.
4. Involvement of the deeper structures even including bone.

Unless the duration and degree of exposure is known, it is very difficult to estimate the degree of damage and the final definition may not be possible until the clinical course has been established.

Immersion Foot—(Trench foot)

This is the name given to a condition resulting from long exposure of the limbs in icy water or to a cold, moist environment. The term is inadequate as the limb need not be immersed and it also occurs in other members.

The severity of the cold is not sufficient to cause freezing but the conduction of heat from the tissues sets up a syndrome that has immediate and disabling sequelæ. It resembles and is probably identical with the trench foot of World War I. After some hours of exposure the feet, which are at first painful, become swollen and numb, the edema involving almost all the exposed part. They are first a livid color which later changes to a pallid waxy appear-

ance and, if the temperature rises slightly, become mottled with blue and green areas. After rescue and exposure to room temperature, the affected limbs pass through three stages: prehyperemia, hyperemia, and posthyperemia.

Prehyperemic stage: At first the feet are numb, the patient feels as though he were walking on blocks of wood and should always be assisted. The color begins to change from pallor to lividity and the legs show various color patterns. Vesicles and even large bullæ appear. There is anesthesia of a stocking type with occasional hyperalgesic areas. The posterior tibial and dorsalis pedis arterial pulsations cannot be detected.

Hyperemic stage: At ordinary room temperature the feet quickly pass into the hyperemic stage. The limbs become hot to the touch and the color a livid red. The dorsalis pedis artery becomes palpable and bounding in character. The circulation is unstable. Congestion appears when the legs are in a dependent position and blanching when elevated. The pain at this period is intense and of a throbbing, burning character. This may last for several days and then change to a shooting, stabbing pain in the dorsum of the foot, radiating to the toes. This may last for several weeks. The edema increases and large blisters are common, especially over the dorsum and malleoli. In severe cases, portions of the foot, usually the toes, remain discolored and cold, heralding the onset of gangrene.

Posthyperemic stage: The hyperemic stage soon merges in a few days into the posthyperemic stage. The burning, shooting pains subside but the feet are subject to intermittent aching pain and edema readily appears when the feet are in a dependent position. The circulation is unstable as evidenced by color changes in different positions. Excess sweating is common and the patients complain of cold, clammy feet. Walking is often difficult as proprioceptive sense appears deficient. The sensitivity to cold, hyperhidrosis and pain may persist for a long time and present a difficult problem in rehabilitation.

Treatment: The aim of the treatment of frostbite or immersion foot is to prevent or minimize necrosis. This has been the subject of a large amount of experimental work and the interest of many military surgeons. It was thought for a long time that slow thawing or warming in frostbite was essential to allow the vessels time to recover their tone and to limit the resulting hyperemia so that the increased metabolic demands of the injured tissues could be met by an adequate blood supply. To accomplish this, the limbs were packed in icebags and cooled with fans or special cabinets. Experimental work on animals in the last few years has indicated that, after quick freezing, less tissue is lost by rapid thawing than by slow warming and that stasis in the vessels is delayed. There is evidence that the larger vessels are in spasm during the chilling period and only relax when the tissue temperature is nearly that of body temperature. While the results of animal experiments cannot always be applied to man it is probable that no harm is done if the frozen part is allowed to return quickly to body temperature or assisted by water at a temperature not above 42° C. Diathermy is being investigated and may be of value.

First aid in the disaster area: The patient with frostbitten feet should be moved on a stretcher and not permitted to walk. No massage or rubbing should be carried out. The frozen area should be covered with a large sterile dressing. The tag should indicate if possible how long the patient has been exposed to the extreme cold so that a rough estimate may be made of the degree of injury. If pain is severe, morphine gr. ¼ hypodermically may be given or a long-acting barbiturate.

Treatment at the hospital: There is frequently some confusion in considering frostbite and immersion foot. Recent experimental work deals almost entirely with frostbite and the casual reader may consider the therapy advocated for acute frostbite as applicable to immersion foot. Actually edema and vesication may appear as an early stage of this lesion and actual freezing with ice formation is not a factor.

Immersion foot or its equivalent, resulting from exposure to moist chilling without freezing, will rapidly pass into the hyperemic state on exposure to room temperature. War experience indicated that cooling had a marked sedative effect, relieving the almost intolerable burning that accompanies this stage. The clinical course is then very similar to that of frostbite and the treatment should follow as described below for frostbite after thawing has taken place.

On arrival at a centre where definitive treatment may be carried out the dressings should be immediately removed and the parts inspected. If blisters are present it is obvious that thawing sufficient to permit some circulation of blood has occurred. The vesicles should be left intact but if they are ruptured the area must be protected against infection.

If the part is still frozen solid it should be allowed to thaw at room temperature. If a comparable group of cases could be observed, it would be of immense scientific value for the attending surgeon to try rapid rewarming in water not over 42° C. A control series could be treated by conventional methods. Pain which is quite marked as the tissues pass into the hyperemic state will require sedation with a long-acting barbiturate or occasionally morphine. Cooling is very useful in controlling the pain.

Pledgets of cotton soaked in Benzolconium Chloride should be placed between the toes to prevent maceration and the whole limb covered with an occlusive dressing or light plaster.

Antitetanic serum and procaine penicillin 300,000 units should be given immediately and the antibiotic therapy must be continued until the danger of infection has passed.

Anticoagulant agents such as heparin or dicumarol may be useful in preventing thrombosis in the injured vessels but they should only be used when adequate supervision is available. Lumbar blockage or lumbar sympathectomy have not been proved of value in the acute phase of frostbite nor in immersion foot where the sympathetic fibres seem to be inactive because of the cold injury. They may be tried, however, if properly supervised as an occasional case is apparently benefited by the procedure. However, in the late sequalæ of painful, sweating hands or feet, where the digits become tapering and shiny, and the movements restricted, sympathetic interruption is of considerable value.

Vasodilating drugs and autonomic blocking agents such as Priscobine, Etamon, and Hexamethonium Bitartrate, etc., have a similar though not as effective action.

ACTH and Cortisone have not been found of value.

Smoking should be discouraged because of the vasoconstrictor action that follows in some individuals.

Necrotic tissue should be carefully debrided but amputation in non-infected cases should be delayed as long as possible. It is surprising how often one may be deceived in mistaking superficial necrosis for gangrene of a large part. Following definitive treatment, physiotherapy is a most valuable aid.

Respecting Human Dignity

The ancient concept of master and servant in employer-employee relationships must be relegated to the limbo of outworn practices that have no place in present-day society . . .

The administrator should command the respect of his personnel. But respect grows spontaneously from the admiration we feel towards a leader, not from fear that a whip may be cracked over our back or that we may lose our job if we invite the displeasure of the "boss." Among human beings it is the quality of our daily give-and-take that counts and leads to mutual respect. It cements the bonds which become indestructible as time goes on. Respect can only be earned by showing all the consideration due to the other fellow who is a partner in our work.

— M. POLLACK, M.D.

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Blessures dues au Froid, Gelures, Immersion des Pieds et Hypothermie

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Les blessures dues au froid ont joué un rôle important dans nombre de campagnes militaires. L'histoire renferme de nombreux exemples des conséquences amères subies par ceux qui se sont lancés dans ces campagnes sans y être bien préparés, ou qui ont été surpris par l'hiver, manquant de vêtements, de vivres et de combustible. Point n'est besoin de beaucoup d'imagination pour se faire une idée des effets d'une attaque sur l'une de nos grandes villes au milieu de l'hiver. Les blessures des victimes étendues au sol et exposées à la rigueur des éléments, à une température au-dessous de zéro, dans l'attente de secours, seraient fortement compliquées par le refroidissement général et par la gelure des parties vulnérables ou exposées du corps. Même les personnes indemnes, jetées hors de chez elles sans vêtements suffisants, ne tarderaient pas à devenir des victimes, si elles ne pouvaient se réfugier facilement dans un abri. Dans le cas où une localité subirait une attaque atomique, le grand nombre des victimes et les souffrances qu'elles se verraient inévitablement infliger seraient horriblement accrus par les effets du froid, de la neige et de la glace, et par l'interruption de la distribution du gaz, de l'huile et de l'électricité, ainsi que d'autres services essentiels. Tout comme dans le cas des autres genres de blessures, des préparatifs appropriés aideront à réduire leur nombre. On devrait constituer des réserves de vêtements chauds, de couvertures et d'appareils de chauffage auxiliaires dans autant de domiciles et d'immeubles que possible. Les équipes de sauvetage devront être bien organisées, de façon à relever les blessés et à abriter les sans-gîte avec beaucoup de célérité.

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Physiologie et Pathologie

Les conséquences de l'exposition d'un membre au froid varient selon divers facteurs, tels l'intensité du froid, la durée de l'exposition, le degré d'humidité et la résistance individuelle. Ce dernier facteur peut être influencé par l'état de nutrition, la fatigue physique, une affection des vaisseaux périphériques, ou la présence chez un particulier de certaines substances mal connues, telles que les auto-agglutinines, qui accroissent sa prédisposition aux lésions par le froid.

Lorsqu'une extrémité est exposée à un froid vif, il se produit de la vasoconstriction qui se manifeste par la pâleur de la peau. Celle-ci peut ensuite passer au rose vif par suite d'une vasodilatation et d'une insuffisance de la dissociation de l'oxyhémoglobine. La vasoconstriction réapparait alors et persiste dans la partie refroidie. Tout le réseau vasculaire est mis en cause, même les principaux vaisseaux. Ce semble être une réaction de défense destinée à maintenir la chaleur corporelle mais elle se produit aux dépens du membre exposé. Le phénomène de la surfusion peut empêcher la solidification de se produire tant que la température ne s'est pas abaissé bien au-dessous du point de congélation ordinaire. A mesure que la température s'abaisse, les tissus refroidis ou surfondus se solidifient, bien qu'on ne constate pas de fragilité dans les cas cliniques ordinaires. L'anoxie résultant de la vasoconstriction peut causer des lésions et les cellules peuvent être réellement endommagées par la congélation. L'état anoxique est aggravé par la stase capillaire, comme on le constate en particulier dans les membres refroidis sans qu'il y ait véritable ge-

lure, alors que le plasma laisse se déposer les hématies. Les tissus gelés peuvent être fortement endommagés par suite de la formation de cristaux de glace qui continuent à croître en brisant les membranes cellulaires. Les effets de la "congélation rapide" ne sont pas aussi évidents que ceux de la congélation lente. La décongélation est suivie d'une réaction inflammatoire prononcée. Cette dernière ressemble à la "triple réaction" à l'histamine et elle pourrait être due à la libération de produits ressemblant à l'histamine sous l'influence des lésions cellulaires. La décongélation se produit de l'extérieur, de l'intérieur, ou le long des vaisseaux par suite de la reprise de la circulation sanguine. Peu après apparaît de l'œdème avec fuite du plasma à travers les parois capillaires endommagées. Des vésicules peuvent se former, en particulier sur le dos du pied, mais elles sont rares sur la face plantaire. La vésication atteint habituellement son maximum en 48 heures. Dans les capillaires, la stase est apparemment due à une simple perte de plasma et peut-être à l'action des autoagglutinines sous l'effet du froid ou du pouvoir anormal d'adhésion des hématies. La température superficielle de la partie en cause est très élevée, probablement en raison de l'ouverture de canaux artérioveineux. Ceux-ci peuvent priver la partie lésée d'une circulation suffisante, vu que la gangrène peut parfois s'attaquer à une partie à laquelle l'apport de sang est apparemment suffisant. A mesure que l'œdème s'aggrave, des zones cyanosées peuvent apparaitre et les tissus dévitalisés sont toujours exposés à l'infection.

Le syndrome qui résulte d'une exposition au froid a reçu divers noms, tels la froidure, l'immersion des pieds, la gelure des tranchées, les engelures, etc. L'effet général du froid sur l'organisme human est communément appelé *hypothermie*.

Traitement de l'Hypothermie

Introduction: Il est facile de concevoir qu'une attaque atomique contre une grande ville durant une période de grand froid ferait des victimes qui souffriraient d'hypothermie ou d'un dangereux abaissement de la température corporelle. Par suite de la très grande étendue qui sera dévastée, le blessé peut être contraint de rester étendu au froid assez longtemps pour subir une grave chute de la température corporelle avant d'être évacué.

Effets de l'hypothermie: Les personnes rendues inconscientes ou souffrantes par un véritable choc oligémique, par exemple lors d'une hémorragie, sont privées du mécanisme protecteur du maintien de la chaleur du corps et sont très exposées à ressentir immédiatement une chute continue de la température corporelle. Les personnes immobilisées au sol par des blessures importantes et exposées au froid pourront probablement conserver leur chaleur corporelle durant plusieurs heures mais, étant couchées sur une surface froide et parfois humide, au lieu de pouvoir marcher pour se réchauffer, leur température corporelle finira par s'abaisser, pour faire d'elles des victimes de l'hypothermie.

Dans ces conditions, la température du corps tombera de 5 à 18° F. par heure (selon la température ambiante) chez la moyenne des adultes et plus rapidement encore chez les gens de petite taille et chez les enfants. A mesure que la température corporelle s'abaisse et que la respiration se ralentit, la fréquence du pouls et la tension artérielle diminuent. La victime devient de plus en plus stuporeuse et, à la température de 82° F., elle devient habituellement totalement inconsciente. A mesure que la température du corps s'abaisse au-dessous de 82° F., la respiration devient de moins en moins profonde, elle se ralentit et finit par cesser totalement. Un peu après, l'arrêt du cœur s'ensuit.

Il est possible de réanimer les victimes hypothermiques, même si leur température s'est abaissée au-dessous de 65° F. Pour ce qui est des températures plus basses atteintes après la perte de connaissance, il peut être très difficile de déterminer si un individu est mort ou non. Si la respiration est à peine perceptible ou si elle a cessé, le cœur peut encore continuer à battre lentement. La tension artérielle étant

réduite, il peut être impossible de déterminer par la palpation et l'auscultation si le cœur bat encore, ce qui, à tort, peut faire passer la victime pour morte. On signale de temps à autre de telles erreurs dans la vie courante.

Selon toute probabilité, la plupart des cas ne présenteront qu'un faible degré d'hypothermie, sans effet apparent sur l'état de conscience et sur la respiration. On peut s'attendre à trouver de la gelure des extrémités chez la plupart des cas d'hypothermie généralisée.

Premiers soins dans la zone dévastée: Aucune mesure spécifique de secourisme n'est recommandée aux équipes de relèvement des victimes, si ce n'est l'évacuation sur le poste de secourisme. Il est peu probable que le personnel de ces équipes puisse reconnaître les cas peu prononcés d'hypothermie. En temps très froid, lors du relèvement de victimes dont les blessures remontent à plusieurs heures, le personnel des équipes de relèvement devrait être en mesure de reconnaître les cas d'hypothermie grave, d'après les indications données ci-haut.

Poste de secourisme: A cet échelon, le principal devoir du personnel consistera à découvrir si une victime souffre d'hypothermie, en déterminant la température rectale au moyen d'un thermomètre à échelle indiquant des températures plus basses que le thermomètre clinique ordinaire. Les hypothermiques seront réchauffés dans une pièce bien chauffée et à l'aide de couvertures chaudes. Les cas graves, dont la température est inférieure à 85° F., réclameront l'administration d'oxygène, peut-être la respiration artificielle s'ils sont cyanosés, et l'évacuation sur un hôpital provisoire. Ceci est important et, si l'affaiblissement de la respiration est prononcé, le traitement idéal consisterait à administrer au malade de l'oxygène sous pression.

Si des cas d'hypothermie sont admis au poste de secourisme, le personnel doit être averti de ne pas considérer l'abaissement de la tension artérielle de l'hypothermie comme étant due à une hémorragie ou au choc traumatique. Une transfusion de sang inutile peut surcharger le cœur.

Hôpitaux provisoires: Le façon de réchauffer les hypothermiques sera, ici, la même qu'au poste de secourisme. On y notera à intervalles réguliers le rythme respiratoire, la tension artérielle, et la température rectale. La meilleure façon de suivre les cas graves dans lesquels il est difficile de percevoir le pouls ou d'entendre les battements du cœur, c'est de se servir de l'électrocardiographe. Encore dans ces cas, le traitement indiqué consiste à administrer de l'oxygène sous pression. Il serait sage de ne pas déclarer morte une de ces victimes, sans preuves électrocardiographiques.

L'arrêt du cœur peut se produire, sous forme de fibrillation ou de défibrillation ventriculaire; il faudra peut-être alors recourir à la stimulation électrique du cœur, si l'on dispose des appareils voulus.

Les stimulants cardiaques seront de peu d'utilité. La principale mesure de traitement consiste à accomplir l'oxygénation complète du sang. Les sédatifs ne doivent être employés qu'*avec parcimonie* dans les cas d'hypothermie, en particulier s'ils affaiblissent la respiration (et de préférence pas du tout).

L'Office des Recherches de la Défense et le Conseil National des Recherches ont récemment mis au point une technique de radiothermie pour ramener à la normale la température du corps. Selon cette méthode, on place le malade entre deux grosses bobines électriques capitonnées. La méthode n'en est encore qu'à la phase expérimentale mais on pourra peut-être se la procurer pour des fins de réanimation.

Au besoin, on peut pratiquer des interventions chirurgicales sur des patients dont la température corporelle dépasse 80° F., à la condition de n'employer que le minimum d'anesthésique et de maintenir une pression positive d'oxygène. Rappelons qu'il faut faire attention de ne pas dépasser le volume sanguin normal par une transfusion excessive de sang, de succédanés du sang ou de cristalloïdes, lorsque le malade souffre à la fois d'hypothermie et de choc traumatique.

BLESSURES DUES AU FROID

Gelure

Ce terme désigne l'état pathologique qui résulte d'une exposition à un froid suffisamment intense et durant une période assez longue pour produire des cristaux de glace dans les parties atteintes. La gelure comporte à ses débuts de la vasoconstriction qu'on peut parfois soulager par une friction vigoureuse, comme on le fait souvent pour les oreilles. Cette pratique empêchera souvent le mal de s'aggraver par suite de l'hyperémie qui permettra aux tissus de se maintenir à une température suffisante. La congélation se produit lorsque les moyens de défense cèdent. L'anesthésie est limitée à la zone gelée, ce qui distingue la gelure de l'immersion des pieds, et l'œdème n'apparaît que lorsque la partie atteinte dégèle. L'évolution du mal est ensuite semblable à celle des lésions dues au refroidissement ou au froid humide. On subdivise ordinairement la gelure en quatre degrés:

1. Rougissement, parfois suivi de desquamation
2. Vésication
3. Destruction du derme proprement dit
4. Atteinte des couches profondes et même des os.

A moins de connaître la durée et le degré d'exposition, on peut très difficilement juger de la gravité du mal et il arrive qu'on ne puisse le faire d'une façon définitive, tant que l'évolution clinique n'est pas bien définie.

Immersion des Pieds (Gelure des Tranchees)

C'est le nom qu'on donne à l'état pathologique résultant d'une immersion prolongée des membres inférieurs dans de l'eau glacée ou d'une longue exposition simultanée au froid et à l'humidité. Ce terme est cependant inexact, vu qu'il n'est pas nécessaire que les membres inférieurs soient immergés et que ce mal se produit aussi dans les bras.

L'intensité du froid ne suffit pas à causer les gelures mais la transmission de la chaleur par les tissus donne lieu à un syndrome dont les séquelles sont immédiates et incapacitantes. Ce syndrome ressemble à la gelure des tranchées de la Première Guerre Mondiale et lui est probablement identique. Après quelques heures d'exposition, les pieds, d'abord douloureux, enflent et s'engourdissent, l'œdème mettant en cause presque toute la partie exposée. Les pieds prennent d'abord une couleur livide puis une apparence exsangue et cireuse et, si la température s'élève quelque peu, ils deviennent tachetés de plaques bleues et vertes. Après sauvetage et exposition à la température ordinaire, les membres atteints passent par trois phases: la pré-hyperémie, l'hyperémie, et la post-hyperémie.

Phase de préhyperémie: D'abord les pieds sont insensibles, le malade a la sensation qu'il marche sur des blocs de bois et qu'il a toujours besoin d'aide. Les pieds, de pâles qu'ils étaient deviennent livides et les jambes présentent diverses colorations. Des vésicules apparaissent et même des cloques. Les pieds sont anesthésiés comme s'ils étaient recouverts de bas, avec parfois des zones hyperalgésiques. Il est impossible de percevoir les pulsations des artères tibiales postérieures et des artères tibieuses.

Phase hyperémique: A la température ordinaire, les pieds passent rapidement à la phase hyperémique. Les membres inférieurs deviennent chauds au toucher et prennent une coloration rouge livide. L'artère tibieuse devient palpable et fait des soubresauts. La circulation est irrégulière. Les jambes deviennent congestionnées lorsqu'elles sont pendantes et elles pâlissent lorsqu'elles sont élevées. A ce moment, la douleur est intense, pulsative et cuisante. Elle peut se maintenir durant plusieurs jours, pour se changer ensuite en une douleur fulgurante et lancinante au dos du pied, irradiant jusqu'aux orteils. Cette dernière peut à son tour persister durant plusieurs semaines. L'œdème s'aggrave et il se produit souvent de grosses cloques, en particulier sur le dos du pied et aux chevilles. Dans les cas graves, certaines parties du pied, habituellement les orteils, restent livides et froides, signe avant-coureur de la gangrène.

Phase posthyperémique: En quelques jours, la phase hyperémique passe progressivement à la phase post-hyperémi-

que. Les douleurs cuisantes et lancinantes s'atténuent mais les pieds sont sujets à des douleurs intermittentes et il s'y produit facilement de l'œdème lorsque les jambes sont pendantes. La circulation est irrégulière, comme le démontrent les changements de coloration dans différentes positions. La transpiration excessive est fréquente et les malades se plaignent d'avoir les pieds froids et moites. La marche est souvent difficile, car le sens proprioceptif semble faire défaut. La sensibilité au froid, l'hyperhidrose et la douleur peuvent persister longtemps et poser un problème de réadaptation difficile à résoudre.

Traitement: Le traitement de la gelure ou de l'immersion des pieds doit viser à prévenir la nécrose ou à la réduire au minimum. Cet objetif a donné lieu à une somme considérable de travaux de recherche et a attiré l'attention de nombreux chirurgiens militaires. On a longtemps pensé qu'il était indispensable de laisser les gelures se réchauffer lentement, afin de laisser aux vaisseaux le temps de reprendre leur tonicité et de restreindre l'hyperémie résultante de telle sorte que les demandes métaboliques accrues des tissus lésés puissent être satisfaites par un apport suffisant de sang. A cette fin, on enveloppait les membres de sacs de glace et on les refroidissait au moyen d'éventails ou dans des cabinets spéciaux. Des expériences effectuées ces dernières années sur des animaux ont indiqué que, après une congélation rapide, il se perd moins de tissu par une décongélation rapide que par réchauffage lent et que la stase est retardée dans les vaisseaux. Certains signes indiquent que les vaisseaux importants sont dans un état de spasme durant la période de refroidissement et qu'il ne se relâchent que lorsque la température des tissus se rapproche de celle du corps. Bien que les conclusions des expériences sur les animaux ne s'appliquent pas toujours à l'homme, il est probable qu'il n'est pas nuisible de laisser la partie gelée revenir rapidement à la température du corps, ou même d'aider ce retour au moyen d'eau dont la température ne dépasse pas 42° C. L'utilité de la diathermie à cette fin est actuellement à l'étude.

Premiers soins dans la zone dévastée: Toute victime dont les pieds sont gelés doit être transportée sur un brancard ; il ne faut pas la laisser marcher. N'effectuer ni massage ni frictions. Recouvrir la partie gelée d'un ample pansement stérile. L'étiquette devra indiquer, si possible, pendant combien de temps la victime a été exposée au froid extrême, afin qu'on puisse se faire une idée approximative du degré de la lésion. Si la douleur est intense, on pourra donner un quart de grain de morphine en injection hypodermique ou un barbiturate à effet prolongé.

Traitement à l'hôpital: On confond souvent la gelure avec l'immersion des pieds. Les travaux de recherches récents se rapportent presque tous à la gelure et le lecteur profane peut penser que le traitement recommandé pour la gelure aiguë est applicable à l'immersion des pieds. En réalité, il peut apparaître de l'œdème et de la vésication au début de cette lésion et la congélation elle-même, qui aboutit à la formation de cristaux de glace, n'est pas à considérer dans ce cas.

L'immersion des pieds ou son équivalent, résultant d'une exposition à un refroidissement humide sans congélation, passe rapidement à la phase hyperémique dès que le malade est transporté à la température ordinaire. L'expérience du temps de guerre a indiqué que le rafraichissement de la partie gelée avait un effet sédatif prononcé, celui de soulager la sensation de cuisson presque intolérable qui accompagne cette phase. L'évolution clinique est par la suite fort semblable à celle de la gelure et le traitement devrait se faire selon les principes énoncés plus loin pour la gelure, après que la décongélation est accomplie.

A l'arrivée d'une victime à un centre où pourra s'effectuer le traitement définitif, on s'empressera d'enlever les pansements et d'examiner les parties atteintes. La présence de vésicules est un signe manifeste que la décongélation est suffisamment avancée pour permettre une certaine circulation du sang. On laissera intactes les vésicules mais, si elles se sont crevées, il faudra

en protéger l'emplacement contre toute infection.

Si la partie est encore fortement gelée, il faut la laisser se décongeler à la température ambiante. Si l'on pouvait observer un groupe de cas comparables, le chirurgien traitant pourrait recueillir de précieux renseignements pour la science s'il faisait l'essai d'un réchauffage rapide dans de l'eau d'au plus 42° C. Un groupe témoin pourrait être traité selon les méthodes traditionnelles. La douleur, qui est bien vive lorsque les tissus passent à l'état hyperémique, nécessitera l'administration d'un sédatif, soit un barbiturate à effet prolongé, soit parfois de la morphine. Le rafraîchissement est fort utile pour soulager la douleur.

On fera bien de placer entre les orteils, pour prévenir toute mortification, des tampons de coton hydrophile imbibés de chlorure de benzalkonium et le membre doit être entièrement recouvert d'un pansement obturant ou d'un emplâtre léger.

On administrera immédiatement du sérum antitétanique et 300,000 unités de pénicilline procaïnique et on poursuivra l'antibiothérapie jusqu'à la disparition de tout danger d'infection.

Les agents anticoagulants, tels l'héparine ou le dicumarol, peuvent être utiles pour prévenir la thrombose dans les vaisseaux lésés mais on ne doit y avoir recours que sous une surveillance convenable. Le blocage lombaire ou la sympathectomie lombaire n'ont pas démontré leur utilité dans la phase aiguë de la gelure, non plus que dans les cas d'immersion des pieds, alors que les fibres sympathiques semblent inactives par suite de la lésion causée par le froid. On peut toutefois en faire l'essai, sous surveillance convenable, car ce traitement semble avoir été profitable à quelques cas. Cependant, dans les séquelles tardives de la transpiration douloureuse des mains et des pieds, alors que les doigts et les orteils deviennent fuselés et luisants, et qu'ils se meuvent difficilement, l'interruption des réactions du grand sympathique est fort utile.

Les médicaments vasodilatateurs et les agents de blocage du système végétatif, tels la Priscobine, l'Etamon et le Bitartrate d'Hexaméthonium, etc., exercent une action semblable mais pas aussi efficace.

L'ACTH et la Cortisone ne se sont révélés d'aucune utilité.

On déconseillera l'usage du tabac, en raison de la vasoconstriction qui en résulte chez certains individus.

On débridera avec soin les tissus nécrosés mais l'amputation dans les cas exempts d'infection doit être retardée aussi longtemps que possible. Il est surprenant comme on peut souvent faire erreur en prenant de la nécrose superficielle pour de la gangrène étendue. Lorsque le traitement définitif est terminé, la physiothérapie offre un précieux concours à la réadaptation.

Rheumatic Fever

Rheumatic fever is a recurrent disease which can be prevented. It is now generally agreed that both the initial and recurrent attacks of the disease are usually precipitated by infections with beta hemolytic streptococci. Therefore, the prevention of rheumatic fever and rheumatic heart disease depends upon the control of streptococcal illnesses. This may be successfully accomplished by (1) early and adequate treatment of streptococcal infections in all individuals and (2) prevention of streptococcal infections in rheumatic subjects. Three per cent of untreated "strep" infections are followed by rheumatic fever, which is responsible for most of the heart trouble in children and a large share of cardiac problems in early and middle adult life.

—*Statement on Prevention of Rheumatic Fever, American Heart Association.—American Practitioner*, Aug. 1953.

Remove the smell of fresh paint by leaving cut onion in the room for several hours. It will absorb the smell of the paint.

The world is full of willing people; some willing to work, the rest willing to let them.
— FROST

Combined Surgical and Medical Nursing

EVA BRACKENRIDGE

ONCE UPON A TIME — not so long ago — the nursing care of a post-operative patient included the administration of a minimum amount of medicine — possibly 1/6 or 1/4 gr. morphine sulfate per hypodermic injection to control pain or restlessness and a 1/60 or 1/30 gr. of strychnine or camphor in oil per hypo when necessary as a stimulant. In some cases Spirits Frumenti were quite the favored stimulant, especially during the outbreak of Spanish influenza. In any case, post-operatively, medication was kept to a minimum.

To prevent or relieve distress from abdominal distention caused by the ever-present "gas pains," sinapisms or cataplasms were the usual order of the day. In an attempt to retain an approximate fluid balance, Murphy drip (per rectum) was considered one of the "musts" among the orders, much to the dismay of patient and nurse alike! In short, the average post-operative patient was listed "surgical" and, as such, not regarded as one requiring much medicine. Their pre-operative welfare was usually completely taken care of by a couple of good old "number nines," and enemata h.s. and a.m. till clear. I wonder how many nurses across Canada can speak from experience of that ordeal.

To the medical patients went the medicines! Patients suffering from pneumonia, tuberculosis, asthma, typhoid fever, influenza, renal and cardiac conditions, all types of rheumatism, all anemic conditions from secondary to Hodgkins; erysipelas and venereal diseases and all other medical ailments, received maximum dosages of all manner and kind of pills, capsules, powders, liquid medicines, and hypodermic injections of numerous drugs. Can we ever forget, as young nurses, administering that first dose of gtts. 1 phenol in the long drink or the gtts. 2 *Oleum tiglii* on a little sugar or that very odoriferous dose of *Tincture asafetida?* Or who can forget the mixed feelings of "kindness and fraud" as we gave that first placebo?

But time marches on, and time changes the picture!

Let us consider Mr. Arthur who, at the age of 36, found it necessary to enter hospital for partial gastrectomy as the result of duodenal ulcer with repeated massive hemorrhage. Mr. Arthur is a mechanic by trade and until 30 years of age had lived an active, normal life, both from a business and social standpoint, and had enjoyed excellent health.

Then came insidious distress in the gastric area. Despite carefully followed medical advice and treatment, including the prescribed diet, he began having hematemesis. About four months before his admission to hospital he had his fourth severe hemorrhage with an almost fatal outcome. Physical examination on admission showed chest clear and lungs normal. Heart and arteries normal, B.P. 120/80, abdomen slightly obese, no masses and no tenderness. Mr. Arthur is a temperate man never having smoked or used liquor. He has always been a great worrier, though, which his doctor felt accounted in part at least for his peptic ulcer.

Previous to the operation, Mr. Arthur had a two-day rest in hospital during which time he had the usual ulcer diet, blood work, typing, etc., done; S.S. enemas, abdominal preparation, gastric lavage, and medication as follows: 500 mg. ascorbic acid daily, S.R. Penicillin 1 cc. h.s. and a.m., Seconal gr. 3 h.s., Seconal gr. 1½ at 8:15 a.m. the day of surgery, and Demerol mg. 100 with Hyoscine gr. 1/150 at 9:00 a.m.

Mrs. Brackenridge, who engages in private nursing in Peterborough, Ont., is chairman of the C.N.A. Committee on Private Nursing.

On return from the operating room his general condition appeared favorable, with slight elevation of temperature, pulse 90, respirations 36, color good. Whole blood, 500 cc., was running intravenously, and a duodenal tube continuous suction with irrigation was started, 200 cc. warm normal saline q. 2 h. in 50 cc. lots being ordered. Other orders included catheterization q. 8 h., patient in Fowler's position, turned q. 2 h.

Medication per hypo during the stay in hospital included: Morphine Sulfate gr. ¼ p.r.n. for pain, Cevalin 500 mg. once daily, Beminal 1 cc. daily, S.R. Penicillin 1 cc. daily, and Streptomycin 1 gm. h.s. and a.m. Continuous intravenous 5% glucose in normal saline, alternating with 5% glucose in distilled water (1,000 cc. — 1,000 cc.) at 150 cc. per hour was also administered.

So much for the first day. The following days, many of which were anxious ones, included the use of Nembutal gr. 3 and Seconal gr. 3 per rectum, Sodium Luminal gr. 3 p.r.n., Codeine gr. 1, Sodium Amytal gr. 1 per hypo. Terramycin, 250-500 mg., was given intravenously in Ringer's (Travert's) solution. Later Darrow's solution was added to the list.

On the tenth day an order for 1 ampoule Synkamin daily was received. Later, Amigen, 1,000 cc. intravenously, followed blood transfusions; 400,000 units Procaine Penicillin replaced the smaller more frequent doses.

Treatments included: linseed poultices, 1.2.3. enemas, x-rays of chest and abdomen, when temperature flared to 105.3° at the end of the second week following surgery. During an attack of jaundice, repeated tests of urine for bile and urobilin were made, numerous blood transfusions given, and clotting and prothrombin timing done.

Diet tolerance began with citrated milk, ounces 1 q.h., and a little clear tea occasionally as desired. At the end of the third week strained thin gruel with cream and sugar, custard, jelly and junket were added to the diet. About this time Mr. Arthur was allowed out of bed for short periods daily and given bathroom privileges. By the end of the fourth week, apple sauce, pureed vegetables, and meat in small quantities were welcome additions to his diet.

Following all this, still another flare-up in temperature occurred, bringing back all the former intravenous therapy and retarding general progress for a time. All the while private nurses were striving to bring about recovery through concentrated effort in the administration of the aforementioned medicines and treatments, also including routine care, such as baths, oral hygiene, keeping him comfortable and doing their utmost to keep up morale of the patient and his family while detours in progress occurred. Repeated consultations of clever, conscientious surgeons and medical men were held in order that they might determine the reasons for setbacks and seek to apply the necessary cure.

Fortunately this story has a happy ending. After approximately two months in hospital, Mr. Arthur was sufficiently recovered to return to his home, a comparatively well and comfortable man. Later he returned to his work and for almost a year he has been able to lead an active, normal life again. It is important and, I believe, well to know that Mr. Arthur was a model patient, always cooperating 100 per cent and rarely allowing himself to become depressed. Truly, he was one of many who today might well be termed a "surgical-medical patient."

How times have changed, and all for the better I firmly believe! Twenty years ago this man's life undoubtedly would have been lost. Today, he lives — a monument to combined clever surgery, modern medicine, plus skilful nursing.

The preservation of health is a duty. Few seem conscious that there is such a thing as physical morality.

— HERBERT SPENCER

Men will confess to treason, murder, arson, false teeth, or a wig. How many of them will own up to a lack of humor?

— FRANK MOORE COLBY

New Safety Container Prevents Poisoning Accidents

CLAIRE HALLIDAY

NURSES HAVE MANY OPPORTUNITIES to spread the good news about an unbreakable container for tablets and capsules that youngsters of five and under can't open. These small pill boxes can be bought in drugstores for 25 cents. If parents will keep their medicines in them, such tragic headlines as: "Iron Pills Kill Baby;" "Tots Playing Doctor, 1 Died," will no longer appear.

The problem of poisoned children — the cause of heartbreak in many homes — has worried the best brains in medical circles the world over. Now this surprisingly simple solution has been discovered — an inexpensive aluminum tube, fitted with a snap closure too complex for the child to solve. In a recent issue of the *Canadian Medical Association Journal*, a Montreal doctor describes this foolproof way of preventing children from poisoning themselves:

> The obvious way to prevent such accidents is to place between tablet and child an unsurmountable obstacle. A medicine chest, located out of reach and always locked, should fulfill this requirement, but this safeguard is often overlooked. The cabinet, loaded with medicine poisonous to babies, hangs within reach of any youngster old enough to drag a chair and climb onto it. Children up to five years are like ostriches: everything goes into the mouth.
>
> One mother kept her iron tablets on the drain board of the sink; her four-year-old son stood on a chair to reach them. He didn't die but his two-year-old sister ate enough to kill her. All drugs are taken from the cabinet some time and only one unguarded moment is required for the curious toddler to help himself. One little girl was left alone in a bedroom where there was a bottle of sleeping tablets. She stuffed a handful into her mouth and swallowed them. Fortunately, she was rushed to the hospital where her stomach was washed out, but not all kiddies reach the hospital in time.

It is, therefore, apparent that the surest and safest way to prevent such accidents would be to dispense and store medicines in containers that cannot be opened by kiddies old enough to be curious but not old enough to realize the danger of eating pills. The overwhelming majority of poisoning accidents occur to children under five years of age, with the peak incidence between two and three. In a group of 244 children under 13 years, admitted to an Australian hospital as a result of poisoning, 47 per cent were in their second year and 29 per cent in their third. The more intelligent the child, the earlier his curiosity manifests itself.

Some poisoning accidents occur not because the child uncorks the bottle but because the cork or cap has been lost or the bottle is left open with the tablets scattered about. A cap that cannot be removed cannot be lost. This new container has three unique characteristics:

1. Adults can easily open and close it.
2. Children under five cannot open it at all.
3. The cap cannot be lost because it is attached.

A cap that cannot be removed.

The reason why young children cannot open it is because they have neither the hand span nor the muscle power that is required. Even if they had the strength, they do not have the coordination. The little hand simply cannot stretch wide enough nor squeeze hard enough in the right place to solve the riddle of the closed bottle. One doctor showed some children how to do it but they were not able to. Yet an adult can open the bottle with the pressure of a thumb and close it with a slight pinch of the fingers.

In a British children's hospital, not one of over 150 youngsters under five years was able to remove the cap, even though their interest had been aroused when the container was filled with candy right before their eyes. The photograph shows young Peter trying to open a container. Tools were placed within reach so that he might try every possible means of getting at the candy.

Dr. D. F. Cross, senior resident of the Alexandra Hospital, Montreal, writes that not one in 100 children was able to open the container. "No normal child under 5 (and in many cases up to 8 or 9 years of age) could open it even if sufficiently ingenious to solve the puzzle himself." Dr. Cross considers it almost 100 per cent safe at preschool age.

What kinds of medicine should be kept in this container? Not just the deadly drugs like arsenic but all tablets and capsules. Every medicine meant for adults is potentially dangerous and may be fatal to young children. Indeed, tablets made especially for children can kill them if eaten like candy and the laudable effort to make all medicine more pleasant for children has definite risks attached. However, it is generally the everyday medicines that take their toll in lives — tablets for the relief of pain, sleeplessness, rheumatism, asthma, laxatives, and tonics such as iron pills. Toddlers have been killed by tablets found loose in mother's handbag. Twin boys died from eating chocolate-coated iron pills found in an empty house. So many have died, in fact, that doctors have recommended that "administrative action be taken to prevent these useful tablets being dispensed in unsafe containers."

Peter cannot open it.

Strychnine in laxative and tonic pills is often the cause of poisoning. During a seven-year period in New York State (not including New York City) there were 158 fatal poisonings of children, five and under, of which strychnine caused 75. Of 32 cases of strychnine poisoning brought into Toronto's Hospital for Sick Children, 6 died. Most of these youngsters had eaten a popular chocolate-covered laxative. Children have been known to eat up to 90 of these pills, considered so mild by adult standards.

It seems odd to grown-ups that the bitter taste of pills never discourages the curious child from eating them. This is because Nature's safeguards against poisoning, the senses of taste and smell, are not fully developed in the small child. Babies chew up and swallow substances that would taste horrible to an adult. Since all children love sweets, it is only natural that sugar-coated pills, especially if brightly colored, should prove irresistible.

Poisoning accidents are definitely on the increase, not only because drugs are today made more appetizing but because children are frequently left with youthful sitters, while their mothers supplement the family income

with work outside the home. If the child is immediately sick and vomits the poison, or a doctor deals with the patient in his office or the home, no official record is made. It is not compulsory to report such accidents in Canada, the U.S.A. or England.

Medicines in liquid form, kerosene, lye, and other dangerous substances must still be kept out of children's way. However, poisonings due to eating pills need no longer occur now that this simple kiddy-proof container has been invented. This container will find many uses — in the home, in mother's purse, in hospital, the doctor's office. Doctors are carrying them in their bags to hold narcotics. Prescriptions can be filled into these containers for a quarter more and extras may be bought to re-pack pills already in the medicine chest. Space has been left on the tube for a label. Nurses on private duty will keep sedatives and other drugs in them. A "Kidipruf" container will be supplied to any registered nurse who sends **10 cents** (to cover packing and mailing) to: *Safety Precisions Ltd., 445 St. François-Xavier St., Montreal 1, Quebec.*

Since the containers are unbreakable, they may be used over and over again. Their purchase, therefore, represents an investment in family safety.

What Price Unity?

EILEEN C. FLANAGAN, B.A.

WE ARE CONSTANTLY SEEING predictions by able writers, prophets, and others, as to what is to happen to all of us in this complex world next year, ten years from now or even in 1984. Perhaps, therefore it would be well for us as Canadian nurses to try to visualize how we will be functioning ten years from now. Will we be a unified, effective organization with our roots going down to each individual nurse, operating perhaps at a comparatively slow tempo or, as an organization set apart from the main stream, functioning more easily and quickly but somewhat aloof from the main body of nurses?

It has been said that "we should realize that just as we criticize our predecessors, so our successors will criticize us." It behooves us then to leave as good an impression as possible.

The C.N.A., like all other large national groups, must function under a suitable constitution to work effectively. The C.N.A. structure like all others is bound to be affected in some respects by the constitution of the country. To a certain extent, these national associations function more smoothly the more nearly they conform to the federal-provincial pattern of the B.N.A. Act. We should try to follow the pattern as long as it does not hamper our objectives but we should have no hesitation in departing from it if it does so.

We should realize that a degree of centralization is needed. Provided that each "part" has an equal share in shaping the "whole," it should be accepted. "Unity" is our greatest need, for without it much of our effectiveness and value to the nurses themselves and to the people of Canada would be lost.

The most important consideration in assessing the value of the Structure Study, with its many recommendations, is to determine to what degree its implementation in whole or in part would enhance the *value* of the C.N.A.

A past president of the Association of Nurses of the Province of Quebec, Miss Flanagan was chairman of the Committee on Legislation, Constitution and By-laws of the C.N.A. when the present Act was approved by Parliament.

to the nurses and nursing interests of Canada. Value rather than time or money should be the criterion.

The C.N.A. was incorporated under the present Constitution in 1947 — six years ago. The By-laws were completely revised in accordance with the Act. It was designed to give equal representation to each province on the central executive, to give proportional representation in the general assembly, to take care of the two major language groups, to serve nurses in the religious sisterhoods on a geographical basis, to give membership in the C.N.A. not only to the provincial associations but also to each individual nurse. The national executive of 26 seemed to be a reasonable number for a group of 30,000 nurses and, while it may be rather expensive, the nurses have obviously agreed to support it since they have authorized an increase of fees to do so. They support its policies since they all have an equal opportunity to formulate them.

We know that because of the size of our country, because of the amazingly different requirements and ways of life in different parts of it, and because of our constitutional structure, unity has to be devoutly wished for and constantly fought for. What better way is there, then, than to have our provincial representatives meet reasonably frequently around a table and discuss their problems, trying to resolve them by "give and take" and goodwill until the best way is found for all?

It is advisable to give these representatives the authority to speak for us within constitutional limits. We should also have well informed membership in the provincial associations who understand the necessity of compromise at times.

For this reason it would seem to be unwise to decrease the numerical size of our national executive, as suggested in the Structure Study. It also proposes to allow the members to speak for themselves individually, rather than for the nurses in the provinces from which they have come. The reducing of costs by cutting the size of the Executive would be short-sighted and detrimental to the attainment of unity of thought, and exchange of ideas among the provincial associations.

The lack of provision for representation of the two language groups is a serious matter. This policy would also mean that urgent provincial problems would not be discussed at the national executive meetings since the members on it were not representing the provinces. In the long run it would tend to make the provinces more distinctly autonomous than they are now.

The idea of individual rather than representative spokesmen is also not in harmony with the original intent and basic principle of provincial representation, on which the incorporation of the C.N.A. was granted.

The theory on which the Structure Study is based is that of creating a national body as such, as nearly free from provincial restrictions as possible, and for which a good case can be made. It has not resolved the constitutional problem of making such a body out of the autonomous provincial bodies of which the C.N.A. is composed. Each of these provincial associations functions in a dual capacity — that is, as a statutory licensing or registering body, and as a professional association. The national association functions only as a professional association.

It is very difficult to see, therefore, how the provincial associations can, unless they separate their two functions, send people to a national association to speak as *individuals*, without any responsibility to the provincial association, since each provincial association is bound by its own laws and by-laws in many matters affecting not only its licensing function but also its professional matters.

At the I.C.N. meeting in 1929 in Montreal, Dame Ellen Musson, the chairman of the I.C.N. Legislation Committee, pointed out this problem in her report and felt that sooner or later it would need to be resolved.

It is realized that the decisions made by this suggested independent national group would not be binding, but would it not be much more useful to get unanimous agreement as we have done

in the past for its major decisions, so that they could be declared to be national policy right from the start?

We could of course set up a Canadian Nurses' Association quite separate from provincial associations, as the Canadian Bar Association has done, to which all nurses would be free to belong, and which would function quite independently from the provincial associations. This would of course bring up the problem of the membership in the I.C.N.

It does not seem to be established by the Study that any better method of securing national-provincial co-operation has been evolved than the one we have now, if it is intelligently used, except that the composition, functioning, and duties of committees does seem to require attention. Would it not be wise to begin on this problem and see whether a lot of the seeming difficulties of the C.N.A. might not straighten themselves out? If not something further could be considered.

It does seem premature to radically alter the basic relationship of the C.N.A. and the provincial associations so soon after the Act of Incorporation, and for no apparently valid reasons. Laws and regulations will not force people to think nationally; only the desire to do so on the part of well intentioned and well informed members will accomplish this end.

The *advantage* of the present constitution under which we operate is *that the C.N.A. when it does decide on any matter is assured of the support of all its constituent parts.* Under the proposed plan, it is very doubtful that this would be so and, in a very short time, *the C.N.A. would be operating in a vacuum without any real authority of its own and probably in many cases without the unanimous support of all its constituent parts.*

The Structure Study has brought to light many problems, and made many recommendations, which we would all do well to consider, but before making any radical change in our present organization we should be sure that it would be a step forward, that everyone would be in agreement, and that we would not lose any of the spirit of cooperation and goodwill that has characterized the Canadian Nurses' Association in the past.

Alberta

THE FOLLOWING ARE STAFF CHANGES in the Alberta Division of Public Health Nursing:

Mrs. McPhail has been named acting director of the Communicable Disease Division until such time as a medical officer is appointed. For many years health unit nurses have requested a nurse consultant in their field so, as soon as a medical director is available, Mrs. McPhail will then act in that capacity.

Edith C. Robinson (Manchester Infirmary and diploma in social studies, Dublin University), on the staff of Western Hospital, Toronto, since her arrival in Canada, has replaced *Sally MacIntyre* in Kinuso. *Mary Leach* (Calgary Gen. Hosp.), who has just completed her public health nursing course at the University of Alberta, is stationed at Sunnynook. *Mrs. Lillian H. Reykdal* is relieving in the Smith district. *Marjorie Mitchell* of Smith is on leave of absence. *Mrs. Leola Edwards* is on duty at Whitecourt while *Mrs. M. C. Faulkner* has taken over the district of Lindale.

Edna Drake, who has been at Sunnynook for the past year, has taken a leave of absence to go to Europe for a visit and further experience in nursing. *Mrs. Anna V. Johnson* of Tangent is on leave of absence to take the course in advanced practical obstetrics at the University of Alberta. *Elizabeth Gibson* of Warner is planning to take the public health nursing course at the University of Alberta. *Helene Pankow* has transferred from Grassland to Peers district. *Mrs. Nina Renwick,* formerly a member of the municipal nursing staff, has transferred from the Oliver Mental Institute to Aberhart Memorial Sanatorium, Edmonton.

Golf is favorite pastime at Banff Springs Hotel — Biennial Meeting, June, 1954.

New Trends in Curricula for Schools of Nursing

GLADYS J. SHARPE, B.S.

EDUCATION — what an amazing and chaotic thing it is! One subject after another is pressed into this bursting portmanteau which ought to be confined to the necessary clothes for a journey through life but becomes a wardrobe of bits of costumes for any emergency. From time to time someone discovers a new need and points out how ignorant we are . . . and so we move toward a curriculum which recalls Burke's description of the Duke of Graffton government — "a piece of joinery, crossly indented and whimsically dovetailed, a tessellated pavement without cement, here a bit of black stone and there a bit of white." To make the chaos more chaotic we mix the clothes together indiscriminately in our curriculum, putting on a costume and pulling it off before we have time to button it up.

In Sir Richard Livingstone's graphic portrayal of general education, nurse educators recognize significant implications and agree with him that "it is not enough to endure or tolerate the ills we have . . . what shall we do?"[1] First let us examine the key word — curriculum.

> As used today in education curriculum refers to any schematic and systematic arrangement of materials of instruction extending over a considerable length of time and planned for a clearly differentiated group of students.[2]

For our purpose it will refer to the program that is developed to prepare students for entrance into the profession of nursing.

It is obvious that for any curriculum to be sound and effective it must be designed with a specific aim in view. At a World Health Organization Working Conference on Nursing Education, participants agreed that the kind of professional nurse needed in all parts of the world is one who is prepared, through general and professional education within *her social structure*, to share as a member of the health team in the care of the sick, the prevention of disease, and the promotion of health.

It was also recognized that in order to achieve that aim the program must be based on the assumption that the preparation of the nurse is an educational process and that the institution or agency, undertaking this responsibility, accepts education as its primary purpose.

Thus in facing the certainty of continuing social and economic changes, nurse educators of the Twentieth Century are intent upon adjusting the system of nursing education to meet the qualitative and quantitative demands for nursing service and, by a strange paradox, in so doing, are reviewing those very principles laid down by Miss Nightingale in her attempt to solve the nursing needs of the Nineteenth Century. In essence these requisites were:

1. That the control of the school of nursing be under auspices other than the hospital.
2. That funds be provided for the operation of the school.
3. That a staff of nurses would be available to care for the patients.

The first school of nursing in Canada was established on the Nightingale plan in 1873. Had the basic principles on which it was founded been maintained by subsequent so-called schools of nursing, the system of nursing education in Canada today would be less chaotic, the curriculum pattern less "whimsically dovetailed" and our nurses provided with a wardrobe appropriate for the journey. In recogni-

Miss Sharpe, who is director of nursing at the Toronto Western Hospital, is first vice-president of the Canadian Nurses' Association.

tion of the inadequacy of the present system, the curriculum, and the product, the Canadian Nurses' Association has enunciated the following policies:

1. That nursing education in common with other education should be incorporated within the educational framework of the country and become the responsibility of institutions, the primary function of which is education.

2. That there is need in the over-all field of nursing service for different categories of workers and, hence, for various types of preparation.

One indication, considered an evidence of progress, is to be seen in the schools of nursing conducted under university auspices. Of the 14 universities across Canada which offer nursing programs, two assume full responsibility for the nature, variety, and extent of all learning experiences in a basic professional program.

In 1933 the University of Toronto School of Nursing established such a professional course in nursing "which would prepare at one and the same time for practice in both hospital and public health nursing." As it was considered that workers at the first level in both fields required a common foundation of skills and knowledge, a basic course common to both was provided. By 1946, having met the exacting standards of the university regarding the inclusion of more of liberal education, this developed into a five-year degree program.[3]

The philosophy which prompted the inclusion of nursing education in McMaster University, the second to offer a basic professional program in nursing follows:

> To meet the health needs of society today, a large number of nurses must be prepared for the general practice of nursing, with smaller special groups prepared as nursing executives and teachers of nursing. The advanced knowledge, the social and technical skills, and the personal qualifications, so necessary to individuals in these special groups, are only to be found in the broadly educated citizen — the citizen who has vision, imagination, and a humanitarian outlook — one whose professional education has been enriched by studies in the humanities and the sciences . . . Is there a more appropriate place for such a preparation than within the university?"[4]

Our answer to this question would be an unqualified negative.

A further indication of the organized profession's concern regarding nursing education resulted in giving approval to a demonstration undertaken to determine whether a professional nurse can be prepared adequately in less than three years. The immediate objectives of the demonstration were:

> (a) To establish nursing schools as educational institutions, separate entities in their own right.
>
> (b) To demonstrate, if possible, that a skilled clinical nurse can be prepared in a period shorter than three years once the school is given control of the students' time.

The evaluation of this demonstration by a joint committee of the Canadian Education Association and the Canadian Nurses' Association epitomized its report as follows:

> The conclusion is inescapable. When the school has complete control of students, nurses can be trained at least as satisfactorily in two years as in three, and under better conditions, but the training must be paid for in money instead of in services. Few students can afford substantial fees nor can the hospital pass on such additional costs to the "paying patient." Some new source of revenue is the only solution.[5]

With 15,457 students enrolled in schools of nursing in Canada and all but 518 of these in hospital schools of nursing, the Canadian Nurses' Association recognizes that the current system of hospital controlled schools is one that is likely to continue for some time. It also believes, however, that many of the difficulties inherent in such a system can be overcome providing certain conditions are met, namely:

> 1. Since the primary function of the hospital is not nursing education, the Committee on Educational Policy advocates the establishment of a committee to act in an advisory capacity to the governing board in all matters pertaining to the education of students.

2. The school should operate on a separate budget which sets forth all sources of income and estimated expenditures. Government aid through financial support should be available only to those schools operating under such conditions as are approved and supervised by the body legally constituted to set provincial standards.

3. The school should be free to plan and to regulate its curriculum in accordance with the educational needs of the students.

In the autumn of 1950 the authorities of a large hospital school decided that the Canadian Nurses' Association demonstration school had established a precedent of educational independence through financial support and that further experimentation was in order. It was recognized that for any institution to claim to prepare professional workers it must provide the organization, the resources, and the facilities necessary to establish its work on an educational basis.

Setting the goals of organizational activity was considered to be the most important step in assuring desired results and the organization's awareness of society's need for more and for better prepared nurses was reflected in the statement of purpose:

> To determine whether, given full control of the students' time, it is possible for a hospital school to achieve the twofold purpose of increasing the number of nurses without adversely affecting the quality of nursing.

To design an educational program, developed in terms of the need, meant an adaptation of method to purpose rather than the adjustment of purpose to method which for 50 years has served to provide good nursing care to hospital patients. The curriculum was completely remodelled, employing materials more suited to the purpose and developed in terms of the services which nurses are expected to render in relation to human and social needs. To implement such a curriculum the principle of educational independence was established and the nursing department reorganized so as to provide for its two aims, nursing education and nursing service — the one student centred, the other patient centred.

With the change in emphasis from service for education to *education then service*, the resources of the community at large were utilized. Thus enriched, not only did the resources provide the necessary learning situations but it was found possible to include them in two instead of three years. Based on a scientific cost accounting of the current three-year educational program, an estimate was prepared showing the probable costs of an experimental two-year plan. Financial assistance was sought and obtained through a charitable foundation and government funds.

The evaluation of this experiment, now in its third year, must be deferred until sufficient pertinent data are available but the authorities are confident that the product of the new curriculum will meet the criteria of the stated purpose.

In recognizing the need for different categories of workers and for various types of preparation, the Canadian Nurses' Association enunciated the principle that standards of education and practice are definitely the responsibility of the professional group and appointed a special committee "to study those problems concerning preparation, legislation, and utilization of auxiliary nursing workers." The report of this committee adopted by the membership has provided much needed guidance to the provincial organizations in respect to a common understanding of title, functions, curriculum, legislation, and interpretation of the role of the auxiliary worker to the medical and nursing professions and the community.

It was felt that a title indicative of the work done should be chosen and it was agreed that the name "nursing assistant" should be adopted. A nursing assistant is defined as "one who has graduated from a recognized school for nursing assistants and who assists with the care of the patient in hospital or home, under the direction of a physician or the direction and supervision of a registered nurse." The functions of this nursing assistant are:

(a) To assist with the care of patients in hospitals under the direction and supervision of a registered nurse.

(b) To assist with the care of patients in homes under the direction and supervision of a registered nurse, or to give care to patients who do not require the services of a registered nurse, under the direction of a physician.

(c) To practise hygienic care of the patient's environment and, where indicated, the required care of the home.

The curriculum was based on the foregoing conception of the functions of the nursing assistant and with an appreciation of the fact that it would be reviewed at stated intervals, to meet changing needs.

The trends in curricula for schools of nursing in Canada would appear to reflect an awareness of the changes in social needs and a corresponding emphasis on the nature of the educational process by which nurses are prepared to meet these needs. The role of the university in preparing the truly professional nurse has been accepted. One new nursing school was established as an educational entity in its own right and successfully demonstrated that a skilled clinical nurse can be prepared in two years. In addition, it provided statistics regarding the actual costs of the educational program. One hospital school has achieved financial and administrative independence through which it has acquired educational control and, while the program is still in the experimental stage, the results to date are encouraging. In each of these latter experiments, government funds were made available, thus establishing a precedent for nursing education in Canada. In many centres in Canada, schools for nursing assistants are augmenting the supply of workers in that category.

In conclusion, if Dr. Livingstone were to evaluate our new educational portmanteau, we would like to think that he would find it less crowded, possibly because the contents were selected with discrimination, and that he would consider it adequate in terms of providing the wardrobe for the journey through a life of service.

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3. University of Toronto School of Nursing Calendar, 1952-53.
4. McMaster *Alumni News*, Vol. 22, No. 2. May 2, 1952.
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Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — London: *Patricia Gagen* (Victoria Hosp., London). Montreal: *D. M. Rowat* (McMaster University, Hamilton). Ottawa: *Réjeanne Lepage* (Ottawa University School of Nursing). Saint John, N.B.: *Mrs. Rena Harris* (P.E.I. Hosp.). Surrey, B.C.: *Dorothy Muirhead* (Winnipeg Gen. Hosp.). Toronto: *B. M. (Mitchell) Buckley* (St. Joseph's Hosp., London), *Jean K. Elliott* (Toronto East Gen. & Orthopaedic Hosp.), *Florence Kerr* (Oshawa Gen. Hosp.), *Gloria M. Somerville* (Public Hosp., Kingston, Jamaica). Truro, N.S.: *Mary Lou Archibald* (Children's Hosp., Halifax). Vancouver: *Barbara E. Blackwood, Daphne Granger* (Vancouver Gen. Hosp.), *J.E.M. Bookham* (Grace Hosp., Winnipeg), *S. M. Van Andel* (Wilhelmina Hosp., Amsterdam, Holland). Winnipeg: *Bernice H. Helander* (Winnipeg Gen. Hosp.), *Suzie Paxton* (St. Boniface Hosp., Man.).

Reappointments — Dartmouth, N.S.: *Isabel Patterson*. Windsor, Ont.: *Mrs. Jane Ouellette*.

Transfers — *Luba Gold* from Winnipeg to Vancouver; *Bertha Klassen* from Sackville, N.B., to Vancouver; *Mary E. Shaw* from Digby, N.S., to Montreal.

Leaves of Absence — Surrey: *Thoran H. Arngrimson*. Truro: *Phyllis Archibald*. Toronto: *Alexandra Holynsky*.

Institutional Nursing

I May be Old-Fashioned but . . .

RHODA F. MACDONALD

FROM WHAT I SEE, hear and read, and have learned from actual experience as a patient on several occasions during the last few years, I earnestly think it is about time we revamped our nursing and adopted some "Old-Fashioned Ideas." I know I am not alone in this concept, for in recent issues of *The Canadian Nurse* different articles have made reference to the idea of more service to our patients.

We are, to all outward appearances, sacrificing the human element in nursing for the technical side. So often we hear from ex-patients — "I seldom saw a nurse," "the nurses are so busy doing this or that, — they are never around when I need them," "they never seem to have time to talk or do little things," "with the modern trend of getting the operative patient up the first or second post-operative day the nurses are of the opinion the patient can now fend for herself and all nursing care or attention ceases."

The patients definitely sense this apparent lack of interest, lack of time, lack of understanding and these are at the root of the discontent and unhappiness that they experience while in hospital.

Directors of nurses and nursing service, instructors, supervisors, head nurses, yes, and members of the medical profession — all those who have contact with the young nurses of today — must by their daily example and instruction clearly demonstrate to them the necessity for treating every patient as a separate individual, each with her own likes and dislikes, personality, and feelings, who does appreciate sympathetic understanding and provision for necessary privacy. The patients as a rule are not intensely interested in the brilliancy of the nurse nor in her achievements academically, but in *what she actually does* to make those who are ill physically and mentally comfortable.

It is time to review our thinking in order that we may be sure that the nurses who are going out into the world to give service, to build and uphold good nursing standards, to take an active part in the life of the community in which they will live, will have a sound foundation in the basic principles which really underlie service. It is essential that nurses be given adequate time to provide good nursing care, to know their patients, to foster confidence, to do the so-called "little things" that add so much to the comfort and well-being of the patient.

Very likely the criticism we so often hear of the inability of private duty nurses to please patients and the reason why nursing attendants or so-called nursing aides or practical nurses are supplying the needs of patients in many homes, is due to the fact that the nurses as students are not given adequate time to understand their patients, to develop insight into human nature, to do the little niceties for them. Nor are the small but very important essentials given the place of importance that they should have in order to do good bedside nursing. Rather these duties are assigned to the ward assistants or aides who, from their more frequent contact, naturally have a much closer approach, learn readily the patient's likes and dislikes, and acquire a better understanding of the patient as a human being.

The time for teamwork is definitely here, with each member, from the highest and most expertly trained person to the non-professional worker, all

Miss MacDonald is school of nursing adviser with the Registered Nurses' Association of Nova Scotia. She lives in Halifax.

cognizant of the fact that the patient is the *main* person, and that all concerted efforts are to be directed towards providing mental and physical safety and comfort for that person. The work should be carried on not in an impersonal manner but in a friendly and cooperative atmosphere. It does not take any more time to be kind nor does it cost anything to be sympathetic and courteous. The keynote should be unselfish service.

Definitely one thing we could recover from the so-called "good old days" is the provision of more time that the nurses may spend with the patients. In such days there were no clinical or bedside instructors but there were interested superintendents, staff nurses, and senior nurses who went with the students, worked with them at the bedside, helped them understand difficult patients and their problems, and saw that they had time to complete the work. Everyone seemed to have an interest in each nurse's development. What we need today is more of these people — clinical instructors, supervisors, head nurses — all imbued with the spirit of true nursing, a willingness to work, to teach, to get in the swim with the students, to get away from their desks, to understand the nurses as well as the patients.

Theoretical education is very essential but are we sacrificing clinical experience and education that should be received at the bedside? Are we doing all we can to correlate theory and our ideas of good nursing with the actual practice of nursing? Are we expecting the nurses to carry out duties that rightfully belong to the medical profession? Are we making our records, reports, etc., so intensive and intricate that the staff does not have the necessary time to devote to actual nursing and teaching duties to help the students do better nursing? Are the nurses who have had postgraduate courses so conscious of their educational attainment that they do not have the right concept of their obligation toward honest bedside care? Do they shoulder their responsibilities in helping to develop good nurses?

We are, I fear, gradually losing our prestige with the general public just as are some of our allied professions and for similar reasons, mainly: lack of appreciation of the patient as an individual with body, soul, and mind; forgotting to practise the golden rule; and a tendency to think of the monetary reward rather than the service we can render.

Let us keep in step with modern developments in medical and other sciences, at the same time adopting and participating in the accompanying activities that require and are adapted to our nursing skills and abilities and that are essential for the safety and comfort of our patients. Let us do *actual* nursing — not become too engrossed in duties rightly the responsibilities of doctors, internes, and technicians. By so doing we can again regain the old-fashioned habit of actually spending the necessary time with the patient to give good nursing care, to have her feel that someone is interested in her welfare, that she is of some account, not just another appendix case, fractured femur, or gastric ulcer in bed or room so and so.

The quality of the nurses of tomorrow depends on those of us who are graduates today. The amount and type of nursing service that will be given both today and in the future reflects the leadership, guidance, teaching and, most of all, the example set by us. Let us set a good example, be old-fashioned once in a while, go all out for good nursing service to each patient regardless of creed, color or race, social standing, ability to pay, or any other factor.

Each of us should adopt the following words attributed to Stephen Grellet, as our resolution concerning our daily work. We can apply it towards all with whom we come in contact, especially the patients. By so doing we shall derive the maximum of satisfaction from our profession:

> I shall pass through this world but once. If, therefore, there be any kindness that I can show; or any good thing I can do, let me do it now; let me not defer or neglect it, for I shall not pass this way again.

Public Health Nursing

It Began on a Balcony

ALMA Y. LONGEWAY

IN DETROIT, during the week of April 2, 1949, less than 24 hours before the end of convention week of the American Association of Industrial Nurses, it was found there were some 40 Canadian nurses present. This was discovered when a handful of us were accidentally thrown together at the Friday night banquet. We all agreed that our presence there indicated that Ontario industrial nurses were seeking something not available at home. Industrial nurses, in the majority of cases, had sat back allowing others to take the lead in professional affairs. The opinion was voiced that no one is better fitted to know the needs of industrial nurses than industrial nurses themselves. It was decided that this would be an ideal opportunity to obtain the opinion of a comparatively large group of nurses from all points of the province. With the cooperation of the A.A.I.N., a meeting was arranged to take place between breakfast and the business meeting Saturday morning.

The meeting opened on the balcony overlooking the huge ballroom. Before we were even close to being finished we were politely informed by a hotel employee that we would have to vacate as there was a private meeting about to begin in the hall below. Well, what now? A porter seeing our plight kindly offered us the use of a cloakroom which we gratefully accepted. So, there we were, huddled together, surrounded by tables, wooden trestles, coat racks, etc., completing arrangements for what was to follow.

The results of that meeting would make one's head spin! ! ! Although some had already begun the long journey home, the 28 nurses remaining were all in agreement that now was the time for industrial nurses of Ontario to take the big step. The opinions were in line with the thoughts expressed in the smaller group the previous night. Before the meeting closed, aims and purposes of the group were outlined and a date was set for what we hoped would be the inaugural meeting of our professional organization for Ontario industrial nurses.

1. *Aim:* To bring together registered nurses employed in industry in Ontario.
   Purpose:
   (a) To stimulate interest in the problems of the industrial nurse and to provide her with means of obtaining experienced counsel.
   (b) To raise qualifications and standards of work.
   (c) To further opportunities in the field of education.

2. *Aim:* To bring together all industrial nurses of Ontario who are registered nurses and encourage them to become — if they were not already — members of their professional organization — The Registered Nurses' Association of Ontario.
   Purpose:
   (a) That we may become recognized as industrial nurses by our professional organization.
   (b) That we, as industrial nurses, may have a voice in the instruction and education of nurses entering this special field of nursing.

The teamwork for which nurses are noted was once again demonstrated. Nurses, who until this meeting were strangers, put their heads and shoulders together. The Welland industrial nurses' organization agreed to make arrangements for a meeting to be held at the General Brock Hotel, Niagara

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Falls, on Saturday, June 4, 1949. Nurses present agreed to contact the legislation convener of the R.N.A.O. and obtain her views. The Industrial Nurses' Educational Association of Essex and Kent Counties accepted the responsibility of assisting in all plans for the meeting and for sending notices to nurses throughout the province. Miss Sarah Wallace, industrial nurse consultant of the Division of Industrial Hygiene, Ontario Department of Health, gave us her usual wise guidance and provided us with an up-to-date list of nurses employed in industry.

Your author, who was at that time secretary of the Public Health Committee of the R.N.A.O., was able, with the assistance of Miss Wallace, to arrange a brief meeting at the annual meeting in late April with the executive of the R.N.A.O. The president and other members of the executive were most receptive and encouraging.

Suddenly, June 4, 1949, was upon us. The inaugural meeting was a tremendous success, with 141 industrial nurses present. A nucleus was formed that was to become, within the year, the Industrial Nursing Committee of the Registered Nurses' Association of Ontario.

It was unanimously agreed by members and non-members at this inaugural meeting, that the reasonable way to accomplish effectively what should be done was to seek recognition from the Registered Nurses' Association of Ontario, stating our problems and proposing methods of handling them. This was done in the form of a brief presented to the Executive and Board of Directors of the R.N.A.O., September, 1949. The brief was reviewed by a joint committee of the two groups at a meeting in November. Out of this meeting came a resolution presented to, and passed by, the Executive and Board of Directors, R.N.A.O., in January, 1950, making us a special committee of the R.N.A.O. with the same privileges and grants as the special interest committees.

This was a great accomplishment as well as a great privilege. However, with this privilege came a responsibility to the committee and to each registered nurse employed in industry. I would like to tell you some of our responsibilities and authorities:

1. To plan and conduct an annual meeting for the industrial nurses of Ontario, within the constitution of the R.N.A.O. and on a date arranged with the R.N.A.O.
2. To transact the general business of the Industrial Nursing Committee in the interim between annual meetings.
3. To plan its program of work.
4. To report the business transacted by the Industrial Nursing Committee to the annual meeting of the R.N.A.O.
5. To consider problems encountered by industrial nurses in their role as professional workers in industry.

Now I shall review some of the achievements of our committee:

1. The presentation of the brief to the Registered Nurses' Association of Ontario gained us our recognition.
2. One of our first projects, at the request of industrial nurses, was a letter to management, with a copy to all nurses, presenting the status of the professional nurse in regard to labor unions. The letter, compiled by our Industrial Nursing Committee, was approved, printed under letterheads, and mailed by our professional organization. We received many grateful replies from managements throughout the province thanking us and commending us for our efforts.
3. Educational programs have been presented in various areas, giving the industrial nurse an opportunity to acquire further knowledge in her special field. These took the form of day institutes, work conferences, etc., planned and conducted by:
   (a) Local organized groups, made possible by the cooperation of managements.
   (b) University schools of nursing.
   (c) In one instance an organized group was approached by a university and a work conference conducted in the location of the group.

Industrial nurses are free to take advantage of these opportunities and are urged to attend refresher courses given by all branches of nursing. Industrial

nurses are also encouraged to take part and, if possible, lead in the civil defence programs for nurses in their area.

4. The Industrial Accident Prevention Association has for the past several years held its annual convention during the same week as the annual meetings of the R.N.A.O. This is conflicting, as all industries cannot release their nurse for the entire week; nor can they send her to Toronto twice within the week. We are faced with the fact that, while some nurses in industry are a part of the team in their safety program, there are a large number of nurses who are the safety directors in their industries. Management is primarily interested in the nurse obtaining all the special guidance possible in safety. The nurse is usually sent to the I.A.P.A. convention. Nurses confronted with this problem requested our committee to offer our assistance to the I.A.P.A. in planning their day for nurses. This we did. The 1953 Nurses' Day was a real success with industrial nurses actively participating. The committee hopes to have a part in planning subsequent programs.

While it may not be possible for nurses to be present for the entire annual meeting, a little effort on their part in selling the value of it to management usually makes it possible for them to return for the Saturday program. This enables them to attend the wind-up of the R.N.A.O. convention and the luncheon that is the opening session of the annual meeting of Ontario industrial nurses.

5. One of the most important undertakings of our committee is "A Guide for Management and Nursing Personnel" published and distributed by the Registered Nurses' Association of Ontario. It is complementary to the R.N.A.O. recommendations on Personnel Policies.

6. Each year preceding the provincial annual meeting a copy of the *News Bulletin* of the R.N.A.O. containing the complete program has been mailed to management with an accompanying explanatory letter. This proved worthwhile when the nurse in industry was a member in good standing. She was prepared for the approach since she already had received a copy of the *Bulletin*. In the event management was too busy to approach her, she was prepared to go to management. There have been instances when a nurse was approached about the convention and had to admit she was not a member. At one annual meeting I found a nurse frantically trying to find out how she could become a member. There she was. Management had sent her but, truthfully, she was not eligible to be there.

7. The Industrial Nursing Committee was formed to act for two years, at which time our status was to be reviewed and careful consideration given, as to whether this committee should be continued and, if continued, whether as a special or standing committee. Prior to April, 1952, it was realized by our committee that we should certainly carry on but that we were not yet mature enough to become a standing committee. In view of this, the committee asked the Registered Nurses' Association to permit us to remain a special committee for another year. This request was granted, bringing us to April, 1953.

In the meantime, the Canadian Nurses' Association completed a Structure Study of the C.N.A. which is being studied by the provincial associations with a view to adopting the proposed structure in part or in its entirety at the provincial level. This may make considerable change in the provincial setup. In view of this it was felt that it would be wise and practical to remain as a special committee.

Local groups, including nurses from several centres, hold frequent meetings. Industrial nurses who are within reasonable distance of an organized group should make themselves known and become affiliated with them. They will find the contacts of tremendous value, not to mention the friendships that grow out of them. For those in isolated places who are interested in knowing the nurses who are closest to them, the committee attempts to provide the links.

In closing, we have received complete cooperation from our parent organization, the R.N.A.O. I want you to ask yourself — have I, as an individual nurse, given *my* cooperation?

Nursing Profiles

Ann Isobel Black has become director of nursing of The Montreal General Hospital thus expanding an active career that has led her into many major responsibilities in her chosen profession.

Born in Sturgeon Falls, Ontario, Miss Black's early years were spent in Edmonton. She graduated from the University of Alberta Hospital, receiving her B.Sc. in Nursing degree following the completion of her course in public health nursing. She joined the staff of the Victorian Order of Nurses after a brief period of service with the Nursing Division of the Alberta Department of Public Health. Following staff experience in Winnipeg, Miss Black became assistant supervisor with the Victoria branch of the Order. In 1941 she returned to Winnipeg to take charge of the student health program at the General Hospital. When the School of Nursing was first organized in the University of Manitoba, Miss Black joined the faculty, teaching public health nursing. She returned to the Victorian Order in 1947 as first assistant superintendent at the National Office. Since 1949 she has been district superintendent of the Greater Montreal branch of the Order.

Miss Black's penetrating mind and ability to grasp problems quickly has made her a sought-after committee member in C.N.A. affairs. She is currently a member of the Finance Committee and is the new chairman of the Editorial Board of *The Canadian Nurse*. She excels in the establishment of good public relations — a very essential characteristic in the executive of a large modern hospital. Widely read, Miss Black is interested in many of the arts.

Paul Horsdal, Ottawa

ISOBEL BLACK

Elizabeth B. Pense, R.R.C., C.D., who has had a distinguished career with the R.C.A.M.C., has assumed her duties as matron of the Military Hospital in Kingston, Ont. Born in Ottawa, Captain Pense graduated from the Hamilton General Hospital

CAPT. (MATRON) E. B. PENSE

and shortly afterwards enlisted with the Non-Permanent Active Militia. Excepting for a year out of the service when she studied for her public health nursing certificate at the University of Toronto, Capt. Pense has been attached to military hospitals continuously. Qualifying as a nursing sister, she was appointed to the Permanent Force in 1939 and was posted to the Military Hospital in St. Johns, Quebec.

With the outbreak of World War II, Capt. Pense was sent overseas with No. 15 Canadian General Hospital and served in England, North Africa, and Italy with that unit. In 1944 she was transferred to No. 5 Casualty Clearing Station, serving in Italy

and Holland. She was awarded the A.R.R.C. in 1945 and returned to Canada. Her responsibilities were increased when she was appointed to the captaincy in 1946. In the next six years she served as matron of military hospitals in Winnipeg, Whitehorse, and Toronto. She received the Canadian Forces Decoration in 1951. The following year she was posted as matron of the Canadian section of the British Commonwealth General Hospital in Kure, Japan, and later the same year took the first group of Commonwealth nursing sisters (British, Australian, and Canadian) to Korea. Under her supervision, Canadian nursing sisters set up a field dressing station, this past spring, 20 miles north of Seoul. Captain Pense was awarded the Royal Red Cross medal prior to her return to Canada in July, 1953, the first nursing sister honored for her services in that theatre.

Having recently completed the requirements for her degree in nursing at Teachers College, Columbia University, **Hester Janette Lusted** has joined the faculty of the School of Nursing, University of Saskatchewan, as assistant professor in public health nursing.

Newton, Ottawa

HESTER J. LUSTED

A graduate of the Regina General Hospital, Miss Lusted has had a varied experience with the Victorian Order of Nurses. She served as staff nurse in Winnipeg and as nurse in charge of the Regina and Port Arthur branches. After two years as assistant to the district superintendent of the Ottawa branch, she joined the staff at the V.O.N. National Office, first as second assistant superintendent, then as a national supervisor in Ontario and in the western provinces.

Exceedingly interested in people — their opinions and reactions, Miss Lusted will find her new duties exciting and challenging as she launches the public health nursing course at Saskatoon.

Elizabeth Anna Bietsch is now the director of nurses at the Medicine Hat (Alta.) General Hospital.

Following her graduation from the Edmonton General Hospital, Miss Bietsch returned there to become a head nurse for three years. Then she accepted the post of night superintendent. In 1944 she received her diploma in teaching and supervision from the University of Alberta and put her new knowledge into immediate use as nursing arts instructor at E.G.H. For the past five years she has been assistant director of nurses there.

ELIZABETH BIETSCH

Currently, Miss Bietsch is first vice-president of the Alberta Association of Registered Nurses, is a member of the C.N.A. Constitution, By-laws and Legislation Committee, and of the Alberta Civil Defence Health Services Committee. She was chairman of the A.A.R.N. Educational Policy Committee and for four years was president of the E.G.H. Alumnae Association. An ardent reader, Miss Bietsch is keenly interested in music. For relaxation from her active professional duties she turns to bowling.

Phyllis C. Bluett, a graduate of the Toronto General Hospital, is director of

nursing service at the General Hospital, Woodstock, Ont., where for many years, following her course in teaching and supervision at the University of Western Ontario, London, she had served as instructor. After completing the work for her B.Sc. in Nursing at U.W.O. in 1946, Miss Bluett joined the teaching staff at Victoria Hospital, London. For several months prior to her present appointment she was assistant director of nurses in Woodstock.

Miss Bluett's interests off duty cover a wide field, ranging from golfing to the Little Theatre and community concerts. Like most of us, she loves to travel.

Thelma D. Green of the Ontario Department of Health, recently appointed Civil Defence Nursing Consultant for the province, is a graduate of the Toronto General Hospital. She has had post-graduate preparation in public health nursing at the University of Toronto and in psychiatric and surgical nursing.

Miss Green brings to her new position many varied skills in nursing, including a broad experience in supervision and emergency work in the industrial health field. She has been closely associated with the Civil Defence nursing program since its beginning. This year will complete her tenth year with the Ontario Department of Health. She is a member of the Federation of Business and Professional Women's Clubs and has been active in connection with jury duty for women. Her interests are golf, painting, and growing roses. She is a member of the Ontario Rose Society, the Toronto Ladies' Tennis and Golf Club, and of the Canadian Handicraft Guild.

Randolph Macdonald Eaton's

THELMA D. GREEN

After 25 years of leadership at the Shriners' Hospital for Crippled Children in Montreal, **Margaret E. Orr** has retired to reside in her old home town of Oakville, Ontario. Following graduation from the Toronto General Hospital in 1914, Miss Orr engaged in private nursing for four years. She then returned to T.G.H. as a head nurse in the Private Patients' Pavilion where she remained until she enrolled in the McGill School for Graduate Nurses in 1927, specializing in hospital administration. She served as assistant superintendent for two years before assuming full responsibility for the administration and nursing service of the Shriners' Hospital.

Nakash, Montreal

MARGARET E. ORR

The blend of Irish and English ancestry that was Miss Orr's birthright gave her a very happy outlook on life that has been reflected throughout her years of active service. Her greatest pleasure always was to have young people, formerly her patients, return to tell of their progress and to bring in wives or husbands for introduction. An omnivorous reader and a lover of flowers, she will now have time to realize her long-cherished dream of having her own garden.

In Memoriam

Estella Appleby, who graduated from Saint John General Hospital, N.B., in 1901, died in Saint John in September, 1953, after a brief illness. Miss Appleby had practised her profession in Maine and Quebec. Prior to her retirement in 1943, she had been on the staff of the Royal Edward Laurentian Hospital, Montreal, for 30 years.

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Florence Juliana Breau, who graduated from the Moncton (N.B.) Hospital in 1928, died there in September, 1953, after an illness of two months. Since 1951 Miss Breau had been director of nursing at the Moncton Hospital. She was a member of the executive of the New Brunswick Association of Registered Nurses at the time of her death.

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Annie I. Brown, who graduated from the Toronto General Hospital in 1895, died this year.

* * *

Katherine May Doak died suddenly on May 23, 1953. She was on the staff of the Toronto General Hospital at the time of her death.

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Ethel Mary Hogaboom died in Toronto on April 15, 1953.

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Geraldine Horne, who graduated from the Toronto General Hospital in 1932, died this year. Miss Horne was formerly on the staff of Sunnybrook Hospital, Toronto.

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Henrietta Le Vesconte, who graduated from the Royal Victoria Hospital, Montreal, in 1898, died in Vancouver on August 2, 1953. Most of Miss Le Vesconte's long and notable career in nursing was spent in the United States. A granddaughter of one of the naval captains who fought with Lord Nelson, Miss Le Vesconte's uncle accompanied Sir John Franklin on his ill-fated attempt to find the northwest passage.

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Annie L. (Parks) Matheson, who graduated from the Royal Victoria Hospital, Montreal, in 1896, died in New Glasgow, N.S., in May, 1953, folowing a long illness.

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Elizabeth McColl, who graduated from the old Protestant General Hospital, Ottawa, in 1894, died in Ottawa on August 29, 1953, at the age of 87. She had been seriously ill for only a short time. At the turn of the century, Miss McColl was superintendent of the Ottawa Maternity Hospital. For a number of years prior to her retirement she was hostess at Holiday House, Aylmer, Que.

* * *

Nora Nold, who graduated from the St. Catharines General Hospital, Ont., in 1929, died there on September 12, 1953. A native of Switzerland, Miss Nold entered the school of nursing soon after her arrival in Canada. Following graduation she remained in St. Catharines for many years as operating room supervisor. For eleven years she was nursing director at the hospital at Baie Comeau, Que. She returned to the staff at S.C.G.H. a few months before her final illness. She had latterly devoted much energy to her favorite project — initiating a fund to be used in establishing a home for retired graduates of her nursing school.

* * *

Georgia P. Pond, a native of New Brunswick who received her training at Wentworth Hospital, Dover, N.H., died in Fredericton on September 10, 1953, following injuries received when struck by a truck. She was 63 years of age. After serving overseas as a nursing sister with the Royal Canadian Army Medical Corps in World War I, Miss Pond joined the Victorian Order of Nurses. She had spent 30 years in this service in Fredericton and was scheduled to retire in September.

* * *

Sally Clough Reid, who graduated from the Toronto General Hospital in 1933, died suddenly this year in Winnipeg.

* * *

Alice Alberta (Brydon) Ritchie, who graduated from the Toronto General Hospital in 1907, died on April 11, 1953.

* * *

Florence Edith Simpson, a graduate from York County Hospital, England, died in Peterborough, Ont., on August 21, 1953, in her 86th year. Miss Simpson came to Moose Jaw, Sask., in 1910. She operated a private hospital there for some years then joined the staff of Saskatchewan's first tuberculosis hospital at Fort Qu'Appelle. She was matron of the Red Cross Lodge

there at the time of her retirement in 1935.

* * *

Elsie Jane Sparling, who graduated from the General Hospital, Guelph, Ont., in 1922, died following a heart attack at Wasaga Beach, Ont., on July 11, 1953, at the age of 52. Miss Sparling's professional career had been spent in hospitals in the United States. She had been on the staff of the Woman's Hospital, Detroit, for the past 15 years.

* * *

Anna Elizabeth Wells, who graduated from the Connaught School of Nursing of the Toronto Free Hospital in 1913, died at Winnipeg on August 15, 1953, in her 62nd year. Following graduation and brief postgraduate experience in tuberculosis nursing, Miss Wells joined the nursing staff of the Toronto Department of Health as tuberculosis nursing supervisor. Responding to urgent requests, she went to Manitoba in 1917 and began her long career with the Department of Health and Public Welfare. Following her appointment as travelling supervisor and assistant to the director of nurses in 1918, she gained an intimate understanding of the problems and needs of the nurses working in isolated areas.

In 1929, Miss Wells was assigned to the task of developing a program of health education. She was responsible for the establishment of the first health series to be broadcast over a radio station in Canada. Eleven years later she turned her attention to developing the very fine library of health and welfare literature that would be difficult to duplicate.

Miss Wells served a term as president of the Manitoba Association of Registered Nurses and was also chairman of the Public Health Section of the Canadian Nurses' Association for two years.

* * *

Mabel Louise Wray, a graduate of the Ross Memorial Hospital, Lindsay, Ont., died recently following a lengthy illness. Miss Wray's professional activities included 14 years as superintendent of Louise Marshall Hospital, Mount Forest, Ont., and four years at Memorial Hospital, Listowel. Ill health caused her retirement in 1950.

Hospital Training in Kenya

ALASTAIR MATHESON

AFRICAN NURSES ARE STILL A NOVELTY in Kenya. In fact none has yet reached the fully qualified stage and the present nursing staff in most hospitals are semi-qualified males — "hospital assistant" is their title. African girls are now getting the chance to qualify and training in nursing is being given both to young men and women at the Medical Training School attached to Nairobi's King George V Hospital.

Of these "nurses-in-the-making," few will reach the fully qualified stage because of the low level of their educational standards. Below the top grade of "Kenya Registered Nurse" is the "hospital assistant" and below that the "assistant nurse."

Janet Ndoti, for instance, left school at Machakos in the Wakamba country after passing through the Second Form. Now, 18 years of age, she is in her second year of training at Nairobi, with a routine of lectures alternating with practical work in the hospital.

Because she left school early, Janet will not have a chance of qualifying as a registered nurse but hopes to become a nursing assistant and eventually to train as a midwife. Then she can return to her home in the Machakos Hills and practise among her own Wakamba people. In the accompanying picture, she and her roommate share confidences.

Central Office of Information Photo

Off-duty relaxation.

Lost! Somewhere between sunrise and sunset, sixty golden minutes. Each set with sixty diamond seconds. No reward is offered, for they are gone forever.

— HORACE MANN

Trends in Nursing

Adult Education Institute

THIS COLUMN IS JUST GETTING in before the deadline because the writer has been doing a small part in developing a "trend." Under the leadership of Dr. J. Robie Kidd, director of the Canadian Association for Adult Education, an institute on adult education was given at Queen's University for those who are in positions which necessitate their giving leadership to persons past school age.

In order to provide a background, perhaps it would be well for us to determine just what the C.A.A.E. is. Dr. Robert C. Wallace, in a letter concerning his acceptance of the presidency of the association, stated:

> It is my conviction that a very important part of our education comes in informal ways and to meet our particular interests. Especially is this the case in our more mature years. The various organizations that serve to this need, each in its own way, are a bulwark to our democratic way of life, for they stimulate our minds and develop our independent and critical judgment. It is the function of the C.A.A.E., to encourage all such organizations to the limits of its ability. You will find a sympathetic ear if you communicate your problems.

Keeping this function in mind, Dr. Kidd arranged, in cooperation with the Extension Department of Queen's University, to present an eight-day institute on the Principles and Methods of Adult Education for those interested in working with adults in universities, churches, business, labor or farm organizations, governments, etc. In order that the sessions themselves might be examples of more advanced trends in education, they were conducted by seminar and workshop methods.

It is not possible to give a complete summary of the material and methods covered but a description of staff members will give an indication of the field:

DR. ROBIE KIDD — As director and coordinator Dr. Kidd was able, from his broad knowledge of the field of adult education in the British Commonwealth, the United States and Europe, to lay the groundwork for the other leaders and to interpret information in the light of Canadian and individual needs.

MR. JOHN OSMAN — On the staff of the Fund for Adult Education and one-time professor of philosophy and football coach (concurrently!), Mr. Osman brought to us a charming personality and an authentic knowledge of how the United States is working to stimulate an increase in the understanding of its culture and of current issues. The Fund for Adult Education, part of the Ford Foundation, does not administer projects but assists in setting them up or in any problems that might arise.

MR. EUGENE HALLMAN — Program organizer for Talks and Public Affairs of the C.B.C. and a collaborator in the radio series "Ways of Mankind" and many others, Mr. Hallman kept us on the edge of our chairs as he discussed writing methods, set us to writing ourselves, and then discussed each effort with the group. As all of us had some creative writing responsibilities, his attack was not on the level of how to write according to the rules of syntax and "compositions" but how to communicate ideas to our own readers. One particularly intriguing assignment, given because it was a common denominator in the experience of the whole group, was to write a book review of the Holy Bible. Given such a task "cold" and without reference material, the results were amazing.

MR. ALAN KLEIN — Mr. Klein, who is with the School of Social Work, University of Toronto, has much skill and experience in group work. How does a group develop? How and why does it break down? Using to a great extent the small committee as a demon-

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Prepared by the National Office of the Canadian Nurses' Association.

stration group, we role-played many personalities which were not difficult to associate with our own colleagues or ourselves. The invariable appearance of the "hidden agenda," the blocker, the "agree-er" and others was demonstrated and means of developing their group consciousness discussed. One particularly enlightening demonstration exhibited what happens to the coherence of the group when members are late. It seems that it is one of the best ways to sabotage a committee. By these negative examples, Mr. Klein was able to instil in us some understanding of the individual *responsibility* to the group and to group thinking. If, when we are sitting in committee, we would have an observer whose function was to watch and listen carefully to the whole meeting and then report those areas of observation that could be improved, our time would be much more productive.

DR. CARTER STORR — After telling us that his part in the institute was not entertainment, Dr. Storr went on to entertain us highly. Being a well known educational psychologist as well as a commercial artist, he was able to give us a great deal of very valuable information in a most acceptable form. For people who have to dream up ideas for posters, pamphlets, reports and other printed materials, he gave us the stuff by which the dreams are made to come true. Of course, he did admit at last that an artist is most happy when he can cut your printed material down to practically nothing, illustrate copiously where needed, and leave a great deal of "air" (which appears to be the word for blank spaces).

As well as these experts, each member was expected to participate. Aside from the information gained, one of the values of the institute was the variety of occupations represented: a nurse whose interest is in health education; a city librarian; a member of the citizenship Branch, Department of Citizenship and Immigration; an educational director of a labor union; three representatives from tuberculosis associations; two from the National Film Board; an Anglican minister working in religious education; two representatives from the Y.M.H.A.; a refugee worker from Jordan on a UNESCO travelling fellowship; a provincial adult education supervisor; a member of a university adult education service; and a volunteer working with a children's film library. It is not hard to imagine all the viewpoints presented during each discussion. Our own feeling was that we all know too little about each other. Nurses, particularly those doing hospital or private nursing, tend to become isolated from the community. Although our own work seems to absorb the greater part of the day, would our contribution as well as our satisfaction not be greater if we were to explore some other activities in our community?

Should any of our readers be interested in a fuller understanding of the scope of adult education, it is possible to take out individual membership in the C.A.A.E. and to subscribe to their publication "Food for Thought." The address is: *143 Bloor St. West, Toronto 5, Ontario.*

For those who would like to know if, when and where there will be further institutes, it would be wise to communicate your interest to the C.A.A.E.

Banff in '54

We have had a glimpse of the entertainment being planned for the Biennial. Better start checking on your jeans and ten-gallon hats!

Orientation et Tendances en Nursing

L'EDUCATION DES ADULTES

CETTE CHRONIQUE arrive à la dernière minute parce que l'auteur a été retenue à l'Association Canadienne pour l'Education des Adultes, lors des journées d'études tenues à l'Université Queens sous l'habile direction du Dr. J. Robie Kidd. Ces journées d'études s'adressaient tout particulièrement aux per-

sonnes chargées de la direction d'adultes.

Peut-être est-il à propos de rappeler ce qu'est l'A.C.E.A.? Citons à cet effet la lettre du président, le Dr. R. C. Wallace:

"Je suis convaincu qu'une partie importante de notre éducation s'acquiert en dehors de l'école, tout particulièrement durant les années plus avancées de notre vie, lorsqu'il s'agit de besoins particuliers. Bien des organisations, chacune à sa manière, sont les gardiennes de notre démocratie. Elles stimulent notre intelligence et développent notre jugement. L'Association Canadienne pour l'Education des Adultes a pour but d'encourager, en autant qu'elle le peut, toutes ces organisations. Vous trouverez une oreille sympathique si vous leur confiez vos problèmes."

Tenant compte de ces remarques, le Dr. Kidd a organisé, avec la coopération de l'Université Queens, huit jours d'études sur les principes et les méthodes d'éducation des adultes. Ce cours s'adressait particulièrement à ceux qui travaillent avec des adultes dans les universités, les oeuvres paroissiales, les organisations ouvrières et d'agriculture, et dans les gouvernements, etc. Ces séances, données sous forme de colloques, cercles d'étude, etc., servaient de démonstration.

Il est impossible ici d'entrer dans les détails mais l'on pourra juger de l'ampleur du sujet par ce qui suit:

Le Dr. J. Robie Kidd — par ses connaissances dans le domaine de l'éducation des adultes dans l'Empire Britannique, aux Etats-Unis et en Europe, était en mesure d'établir un canevas du travail à accomplir durant ces journées d'études et d'interpréter toutes les informations à la lumière des besoins du Canada et des participants.

M. John Osman — membre du personnel du Fonds pour l'Education Adulte, était autrefois professeur de philosophie et entraîneur de football et ce, conjointement! Il nous a fait connaître les méthodes employées aux Etats-Unis pour stimuler la compréhension de la culture et des questions actuelles de ce pays. Le "Ford Foundation" a un fonds pour l'éducation des adultes. Elle n'administre aucune organisation mais elle aide à leur établissement et à la solution des problèmes pouvant se présenter.

M. Eugene Hallman — en charge à la C.B.C. des programmes intitulés "Propos sur les Affaires Publiques," a discuté des méthodes d'écrire, non pas au point de vue grammaire et syntaxe mais sur la façon de communiquer nos idées aux lecteurs. Le groupe a dû faire la critique d'un livre — La Bible — et le travail de chacun fut discuté.

M. Alan Klein — de l'Université de Toronto à l'Ecole des Travailleurs Sociaux, a beaucoup d'expérience dans le travail de groupe, la formation d'un groupe, sa désagrégation. Comme démonstration, l'on forma de petits comités. Bien que fictifs les rôles nous rappelèrent souvent le comportement de nos membres. La surprise d'un "nouvel ordre du jour," la rencontre de celui qui est toujours contre et de l'autre qui dit toujours oui, sont des choses familières. La démonstration portait sur la manière de conduire la discussion. Dans une autre démonstration l'arrivée en retard de membres du comité nous a fait juger de l'effet néfaste de cette pratique. En un mot, M. Klein nous a fait comprendre la responsabilité de chacun envers le groupe. Il nous fut conseillé, lorsque nous siégeons en comité, d'avoir un observateur chargé de surveiller et d'écouter attentivement et de faire rapport de ses observations à différentes périodes. Nous pourrons aussi améliorer la qualité de nos séances et épargner du temps.

Le Dr. Carter Storr — a été très intéressant. Il est bien connu comme psychologue et artiste commercial. Aux personnes songeant à de belles affiches, à des publications, il a donné la recette rêvée. "Retenons que l'artiste n'éprouve aucun plaisir à réduire notre texte à à peu près rien," dit-il. "Il faut illustrer copieusement lorsqu'il y a lieu de le faire et aérer le texte au besoin."

En plus de bénéficier des connaissances d'experts, les membres des journées d'études, travaillant dans des domaines divers, ont eu grand plaisir à se rencontrer. Il y avait une infirmière en hygiène publique; un bibliothécaire; un membre du Département de la Citoyenneté et de l'Immigration; un directeur de l'éducation d'une union ouvrière; trois représentants d'associations anti-tuberculeuses; deux représentants de l'Office National du Film; un ministre du culte; deux représentants du Y.M.H.A.; un réfugié de la Jordanie, boursier de l'UNESCO; des éducateurs, etc. On s'imagine facilement la diversité des points de vue. Personnellement je suis d'avis que nous ne nous connaissons pas suffisamment.

Les infirmières, particulièrement celles qui font du service privé ou hospitalier, ont une tendance à s'isoler. Bien que la plus grande partie du jour soit prise par notre travail,

ne serait-il pas à notre avantage de connaître et de prendre part aux activités de la communauté?

Si quelques-unes de nos lectrices désirent connaître davantage l'envergure de l'éducation des adultes, elles peuvent s'inscrire comme membre à l'A.C.E.A. en s'adressant à *143 ouest rue Bloor, Toronto 5, Ontario.* Vous recevrez l'intéressante publication "Food for Thought."

Banff en '54

L'on vient de nous communiquer le programme récréatif du Congrès de 1954. Préparez-vous, les "jeans" et les sombreros seront de mise!

Chez les Notres

L'ouverture des classes nous ramène des voyageuses enthousiasmées. Mlle G. Charbonneau, directrice de l'École des Infirmières Hygiénistes de l'Université de Montréal, revient d'un voyage en Amérique Centrale où, sous les auspices de l'O.M.S., elle a fait un séjour d'étude. Elle a revu, au travail, quelques-unes des anciennes diplômées de l'école qui lui ont fait un chaleureux accueil.

Experience Additionnelle

L'Hôpital Notre-Dame de Montréal offre aux infirmières des cours, leur permettant d'acquérir une expérience additionnelle dans le domaine de l'obstétrique, la médecine générale, la chirurgie, la salle d'opération, la chirurgie nerveuse, et la chirurgie thoracique. Ces cours, d'une durée de 26 semaines, offrent une période d'orientation et une expérience très variée. Les infirmières intéressées pourront obtenir plus de renseignements en s'adressant à la *Rév. Soeur Mance Décary, Hôpital Notre-Dame, 1560 est rue Sherbrooke, Montréal 24.*

Ces notes sont préparées par un membre de l'Association des Infirmières Canadiennes.

Annual Meeting in Alberta

Banff was the locale of the 35th annual meeting of the A.A.R.N. which was called to order by the president, Frances Ferguson, on May 27, 1953.

The interesting reports presented indicate that it has been a busy year for the association and will be busier still as more and more tasks develop in preparation for the biennial meeting in June of next year.

Mrs. Van Dusen presented the highlights of association headquarters activities for the year, including: statistics regarding membership; distribution, on a trial basis, of a uniform Constitution and By-laws to the four registries; reports of various institutes and refresher courses; and action taken on the resolutions from the 1952 annual meeting. Five new chapters have been formed since September, 1952, at Cardston, Pincher Creek, Turner Valley, Olds, and Vermilion. The Drumheller Chapter has been reorganized with Hanna as the new centre. A chapter also has been formed at Whitehorse, Yukon.

Plans for the C.N.A. biennial meeting at Banff in 1954 were reported. Close coordination is being maintained with National Office in the arrangements and invaluable help is being given by Mr. R. McLean, public relations officer with the Department of Economic Affairs of Alberta.

Animated discussion followed the presentation of the report of the Finance Committee by its chairman, E. Bietsch. The association fees were raised to $15.00 for active membership and $2.00 for associate membership.

Two facets of the Structure Study were presented, one being the audio-visual arrangement "Operation C.N.A." prepared by the R.N.A.O. Participants were H. Penhale, E. Bietsch, C. Van Dusen, Sr. M. Laramee, and 12 other members.

The reports of the special interest sessions showed that good work is being done in recognizing problems, analyzing them, formulating plans and instituting action. The Educational Policy Committee has been very busy, having produced an outline of policies on nursing education which has been accepted by the C.N.A. Executive Committee. Also, it was on a recommendation from this group that the C.N.A. set up a special committee to study the preparation of auxiliary and professional personnel to care for the mentally ill.

Two of the important resolutions passed were: that a provincial student nurses' as-

sociation be formed; and a strong protest at the deletion from the provincial Hospital Regulations of the section requiring that the graduate nurse staffs of approved hospitals be registered.

The meeting voiced the regret of all members for the loss of Miss Chittick and their pride in the eminent post she now fills as the director of McGill School for Graduate Nurses.

A most stimulating and timely panel discussion provided food for thought on "The Rehabilitation of the Orthopedic and Poliomyelitis Patients." The contributors, each presenting a different angle of the problem, were: M. Baxter, director of nursing, Junior Red Cross Hospital, Calgary; Dr. R. G. Townsend, orthopedic surgeon; K. Coutts, physiotherapist; M. Story, public health nurse; and E. B. Cameron, occupational therapist. Another very interesting presentation was the Civil Defence demonstration narrated by Evelyn Pepper of the Civil Defence Health Planning Group, Ottawa, with L. Kremer as the nursing consultant.

Guest speakers were F. McQuarrie, assistant general secretary, C.N.A., who described the day-to-day work in National Office and its effect on Canadian nursing; and Dr. C. W. Taylor, who gave an interesting talk on "Early Diagnosis of Lesions of the Brain and Spinal Cord."

New officers elected were: President, Helen Penhale; vice-presidents, E. Bietsch, K. M. Morton; councillor, Sr. M. Laramee. Committee chairmen: Institutional Nursing, J. Morrison; Private Nursing, Mrs. T. McLeod; Public Health Nursing, Mrs. M. Larson.

CLARA VAN DUSEN, *Registrar*

Annual Meeting in Prince Edward Island

THE 32ND ANNUAL MEETING of the Association of Nurses of Prince Edward Island was held in Summerside on September 17, 1953. Total registration for the full day's meeting was 74. The president, Verna Darrach, presided at all meetings.

The morning session began with the presentation of a few reports. Following the reports, Pearl Stiver, general secretary, C.N.A., addressed the meeting, speaking on the topic "Picking Up the Threads." A film, sponsored by the C.P.R., was shown to stimulate interest in attending the Biennial Convention at Banff in 1954.

The afternoon session opened with an invocation by the Rev. Donald MacKay, Summerside, and an address of welcome by the Deputy Minister of Health and Welfare, Dr. O. H. Curtis.

In her presidential address, Miss Darrach spoke on the question "What is Nursing?" presenting ideas reported by the Working Conference on Nursing Education of the World Health Organization — that nursing, once concerned only with the care of the sick, has vastly extended its scope in the personal and human approach to the patient as an individual. The responsibility of the nurse as supervisor and teacher to student nurses, the auxiliary worker, and the family was stressed. In giving "patient-centred" care, the nurse should focus not only on the physical needs of the patient but on the social and psychological needs as well.

The report of the secretary-registrar summarized the various activities of the Executive Committee and the reports of representatives to other professional group meetings were discussed. Also noted was the Pediatric Nursing Institute and the progress of the Committee on Evaluation — three educationalists who evaluate all academic credentials for applicants to schools of nursing in P.E.I.

Part of the afternoon was given over to the audio-visual presentation of the Structure Study of the C.N.A. — "Operation C.N.A." After the presentation, the members also participated in discussing briefly some of the controversial changes. The remainder of the afternoon session was spent on reports. The Committee on Legislation and By-laws presented an extensive revision of the by-laws. Two new by-laws were added — one to provide for an interim certificate of registration and the other "Honorary Membership." The Committee on Employment Relations presented personnel policies for the private nurse, adding to the recommendations passed at the last annual meeting for the institutional nurse.

Miss Stiver, who was again the speaker

at the well attended dinner, took as her topic "The I.C.N. Congress in Brazil." She drew a word picture that made her listeners feel the thrill of meeting with 1,300 nurses from 46 countries and pride in that they were Canadian nurses. She added that because of the high regard in which nurses and nursing in Canada is held, Canadian nurses have a great responsibility to maintain this position. The Minister of Health and Welfare, who was unable to be present in the afternoon, attended the dinner and spoke briefly when called upon by the president. It was moved that Anna Mair, a past president of the Association of Nurses of P.E.I., be made an honorary member. This was carried unanimously with applause.

Verna Darrach was returned as president for her second term, other officers being: Vice-presidents, Sister Mary Irene and Ruth Ross; honorary treasurer, Mrs. Mary Bradshaw; honorary secretary, Hazel Adams.

MURIEL ARCHIBALD,
Secretary-Registrar

In the Good Old Days

(The Canadian Nurse — NOVEMBER 1913)

"I urge all nurses to acquire a working knowledge of serums, vaccines, toxins, and phylacogens. I do not hesitate to say that less than 10 per cent of professional nurses know anything about them or their administration. You may answer that these remedies are new; there is plenty of time. I grant they are new but it seems reasonable to me to forecast that in the next few years the biologics will constitute at least 50 per cent of the therapeutic agents used by doctors."

* * *

"The factory owners of this country are coming to realize that if the output of their factories is to be up to the standard, they cannot afford to have men laid aside for indefinite periods. The managers of these concerns have aided as far as possible to keep their number of workmen constant by bringing in the factory nurse who plays an important part in filling a long-felt want."

* * *

"The school hygiene movement has at last become a positive movement for the advancement of the health of the school child rather than a negative summing up of the incidence of disease. There is less emphasis on the pitiable condition of bad teeth and more stress on the advantages of good teeth."

* * *

"Many training schools are recognizing the necessity of having *paid* instructors if they are to be successful. How to secure these instructors is the question. A new suggestion is being studied that where one school alone could not afford to engage a salaried instructor, two or three might unite and so secure the services of this valuable official."

* * *

"Shall pupil nurses be sent out on private cases during their training or not? It seems to us absolutely wrong and blameworthy to send out these pupils to earn money for the hospital. To make the thing more glaring, some hospitals boast of all the money its pupil nurses have earned. When will graduate nurses waken to their duty, their opportunity, to do something about this situation?"

* * *

"The General and Marine Hospital, Collingwood, Ont., is constructing a new nurses' home which will cost $8,500. The new building will be a handsome two-storey brick structure with ample accommodation for the lady superintendent and 15 nurses."

To be ambitious of true honor, of the true glory and perfection of our natures, is the very principle and incentive of virtue.

— SIR PHILIP SIDNEY

What am I?

I am a little thing with a big meaning — I help everybody. Unlock doors, open hearts, do away with prejudices — I create friendship and goodwill; I inspire respect and confidence. Everybody loves me. I bore nobody. I violate no laws. I cost nothing. Many have praised me, none has condemned me. I am pleasing to everyone. I am useful every moment of the day, I am — *Courtesy.*

Hi, There! Student Nurses

JUNE 7 TO 11, 1954! Now *there* is an important time for all of us student nurses to remember! As you probably know, that is the week set for the Biennial Meeting of the Canadian Nurses' Association at Banff.

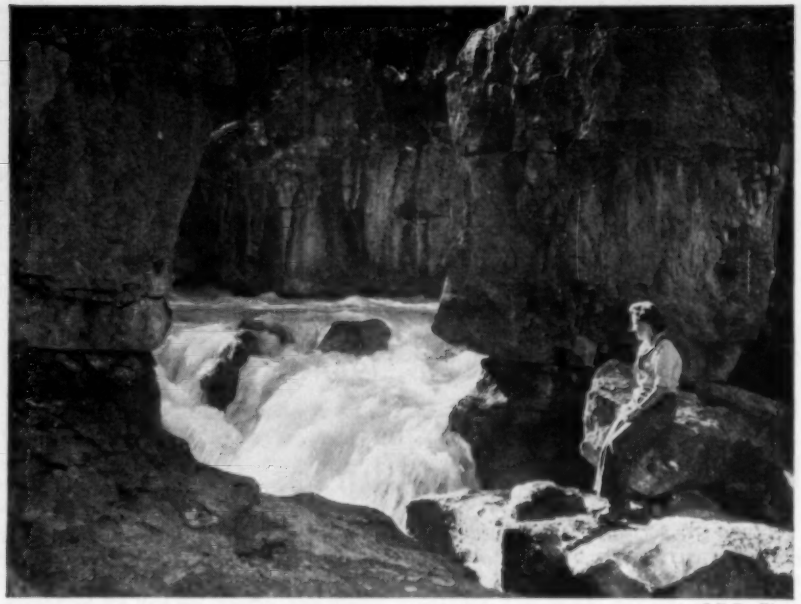
Perhaps you have had an idea that it might be rather a dull business for a student to sit through the sessions of a convention where graduate nurses are discussing all kinds of things that tie in with our profession. Do you see that last pronoun? It is *our* profession they will be talking about, even if we are only fledglings so far. Moreover, the program isn't just an endless series of reports, if rumors we have heard can be believed. There will be up-to-date information on a good many things that nurses take a lively interest in, including panel discussions and demonstrations of a variety of useful techniques.

Those of us who were in training at the time our student representatives returned from the 1950 C.N.A. convention in Quebec City well remember how enthusiastic those girls were over the special sessions for students that had been included in the program. We learn that there are to be more of these "specials" next year too. Wouldn't it be really something if we could have at least one girl with us at Banff from every school of nursing in Canada?

If you are one of the lucky ones selected to represent your school, we want to give you just a few hints about Banff and where we will all be living. Of course, if you have been to Banff before you will know some of these things already. However, it is a long way from, say, Halifax or Montreal or Toronto, so perhaps you don't know what the weather may be like in the mountains at that time of the year, what you wear for sightseeing, and so on. There are so many beautiful places to see and it would be such a pity for anyone to come so far and not be able to go on the special trips that are going to be available.

First of all, we shall be living and working or playing in an altitude that is nearly a mile above sea level. Second, with the convention coming the first week in June, there will probably be snow well down on the mountain sides. Even though it may be quite warm enough during the day for summer clothes, it gets cool — sometimes even definitely cold — after sunset.

Maybe if you are panting in the midst of a heat wave when you are doing your packing you will think, "It couldn't possibly be cool enough to wear a woollen skirt and sweater," or "I'll take my cotton slacks instead of my flannel ones." Don't say we didn't warn you, though!



C.P.R. Photo

Canyon, Panther Falls, Icefield Highway-Columbia, Icefield, Alta.

Another important item to think about is your shoes. We are to have two free afternoons when we can go sightseeing. You don't want to be stuck at home because you forgot to bring a good solid pair of shoes to hike around in. Get them half-soled early, girls!

The Arrangements Committee realized we don't have too much money to spare so they are arranging for us to stay in comfortable dorms away from the big (and expensive) hotel, if we want to. We'll have fun there but we'll have to go out to go to the meetings — and there are no street cars or buses in Banff! Nobody needs to suggest that we students should practise walking to harden up our muscles. We do plenty of walking now. But remember again about those shoes!

There will be lots of us from Alberta in Banff to welcome you. We are looking forward to it tremendously. We suggest that you look up the October issue of *The Canadian Nurse* right now and tear out the registration form for future reference. Who knows? You may be chosen as the one to go. Be seeing you! — G. CANN *and* A. PAGE

Enthusiasm

Enthusiasm is the greatest asset in the world. It is greater than money, power and influence. Singlehanded the enthusiast convinces and dominates where the wealth accumulated by a few would scarcely raise a tremor of interest. Enthusiasm tramples over prejudice and opposition, spurns inaction, storms the citadel of its object and like an avalanche overwhelms and engulfs all obstacles. It is nothing more or less than faith in action. Faith and initiative rightly combined can remove mountainous barriers and achieve the unheard of and miraculous.

Set the germ of enthusiasm afloat; carry it in your attitude and manner; it spreads like contagion and influences all around you before you realize it. Enthusiasm means joy and pleasure, satisfaction and life, real and virile.

— *U.N.A. Nursing Journal*, April, 1953.

Focus on . . .

Armchair Treatment of Myocardial Infarction

Drs. A. M. Mitchell, Bernard Lown, and S. A. Levine, of the Department of Medicine of the Harvard Medical School, Boston, state in an article in the *American Journal of Nursing* for June, 1953, that the heart obtains the greatest degree of rest, not in the traditional "bed rest" but when the patient is sitting up in a comfortable armchair. They add that the person with acute myocardial infarction is characteristically a husky, healthy man who has rarely been ill. Small wonder then that during an acute episode he is beset with anxiety and apprehension. He may be in bed but he is not at rest.

Some years ago, one of the writers was asked to see a patient who had suffered an acute myocardial infarction a few days earlier. The patient was sitting up in bed, gasping for air, with blue lips and fingernails, and neck veins perceptibly swollen. His lungs were filled with fluid, in which he was slowly drowning. It was decided to get him up to see if the force of gravity might not remove this fluid from the lungs to his legs. While the resulting swelling of the legs might be unsightly, it would be less dangerous, until the heart had recovered some strength and efficiency. The results were spectacular! In a short time the breathing was slower and less labored and his color changed to a more normal pink. The patient did well for the rest of his illness, recovered, and lived for many years.

That dramatic clinical experience led to the conclusion that strict bed rest is more taxing to the damaged heart than a sitting position in a comfortable armchair. So started a new method of managing patients with acute myocardial infarction.

Advantages of the Armchair Method

1. The tendency to accumulate fluid in the lungs, which leads to pulmonary edema, is much lessened when the patient is in a chair.

2. The sudden transition to the complete helplessness of a bed patient, together with his fears, is often more than the patient can accept. As a result, he gets dreadfully depressed. Since the work of the heart is increased with emotional upset, the patient is not really at rest either emotionally or physically. If he is allowed to sit up in a chair, almost immediately after the onset of his attack, his condition does not appear to be so grave and he faces the future with greater confidence.

3. Sitting up in a well padded chair is immeasurably more comfortable than continuous bed rest.

In prolonged bed rest there are a host of uncomfortable and even dangerous sequelae, particularly to older patients: loss of appetite; constipation; the possibility of clot formation in the veins of the lower extremities from the stagnating of blood due to pressure on the calves. There is the great danger of pneumonia when a patient lies in bed; if the patient has an enlarged prostate gland he may develop urinary retention and urinary tract infections. The breakdown of skin at pressure points with consequent development of decubitus ulcers is an ever-present nursing problem.

Technique of the Method

In most cases the patient may be out of bed in the first two days, remaining in the chair as long as he is comfortable, returning to bed when he feels too tired to sit up any longer. With the chair at the bedside, two people, one on each side, help the patient to get out of bed. His legs are first dangled over the side of the bed; then he stands, and is guided and helped into the chair.

The patient is not permitted to bathe himself, though he may be allowed to feed himself early in his hospital stay. It is thought that this extra effort is offset by the increased comfort and higher morale produced by feeding himself. He may generally comb his hair but may not shave himself. The bedside commode is used rather than the bedpan.

As soon as the patient arrives on the ward, the nurse carefully explains to him that he must remain quiet. The doctor should discuss the armchair routine in detail with the nursing staff. It is vital that they all understand thoroughly that the armchair treatment is not meant to allow the patient *more physical activity* than the traditional bed rest but is designed to ensure him

maximum rest. The role of the nurse thus becomes a key factor. She supervises and carries out the planned program of care, giving to each case the close attention that her understanding of the principles and objectives of therapy call for.

In the opinion of the doctors, there are few complications of acute myocardial infarction in which the armchair treatment is contraindicated. Severe shock, extreme debility and weakness, or a concomitant cerebrovascular accident are the only conditions, they say, that make the treatment undesirable. "The presence of high fever, severe pain, a need for oxygen, or cardiac irregularities do not prohibit the use of the chair."

RESULTS

There is no evidence that mortality is increased by the armchair method. Rather, the percentage of deaths in these patients is somewhat lower than the percentage in a comparable group of bed-treated patients. Many patients show dramatic improvement as soon as they are up in a comfortable chair. The incidence of complications is decidedly less and there is a noticeable rarity of pulmonary edema. The writers state that there are no known disadvantages. It promises to be superior to the prevailing method, though more extensive experience will tell if it should become the standard form of therapy.

An Egg for an Eye

In *Medical Times* for August, 1953, Drs. Maurice Croll and L. J. Croll report on an interesting and valuale use of egg membrane in the treatment of chemical injuries to the eye. The eggs are boiled for 20 minutes and brought to the operating room in a sterile container. They are peeled so that two large pieces of the membrane can be removed intact and the rest is removed in strips 1½ by ¼ inches.

When a patient is first seen after injury to the eye, pontocaine 0.5% is instilled in both eyes and, if necessary, the patient is given an injection of demerol or morphine sulfate. The history of the injury is obtained and careful examination made. Atropine is instilled into the eye and a 30% sodium sulfacetamide solution is instilled intermittently into the conjunctival sac. The cornea and conjunctiva are irrigated with warm sterile water and any foreign particles gently removed.

After more pontocaine is instilled into the eye, one of the square pieces of egg membrane is laid over the cornea and sutured above, while the other large piece, also covering the cornea, is sutured below. Each is molded to fit the contour of the cornea, thus making a double protective layer. The long strips of membrane are rolled together and packed into the upper cul-de-sac and pieces of it are also used in the inner and upper canthus. Pressure dressings are then applied to both eyes.

The dressings are first changed in 72 hours when, if healing is progressing, the rolls of egg membrane in the cul-de-sac will "roll out." The cornea is inspected by lifting up the curtains of membrane, but they are left until the sixth day when the sutures are removed. In the 26 cases treated by this method, the results have been excellent and follow-up shows that sequelae are reduced to a minimum.

The difficulty in the past, with chemical injuries to the eye, has been to prevent adhesions forming between the two layers of conjunctiva, when both surfaces have been burned. The results to date with egg membrane would indicate that it is well worth trying, as no other treatment has so far given comparable results.

Happiness is not in our circumstances but in ourselves. It is not something we see, like a rainbow, or feel, like the heat of fire. Happiness is something we are.

— JOHN B. SHEERIN

Sincerity is to speak as we think, to do as we pretend and profess, to perform what we promise, and really to be what we would seem and appear to be. — TILLOTSON

Student Nurses

Service

NORA RIEGER

IN MANY COMMERCIAL PLACES we find slogans like "Service with a Smile," or "Money refunded if we fail to smile when serving you," or "We aim to serve you well." To the commercial man it seems to be of importance to give good, cheerful service to promote his business.

What, then, is this service which he is so anxious to give to his customers? In the dictionary we find the word "service" defined as follows: "To perform duties for, to be employed in labor, to wait on, to give assistance to, to yield obedience to, a kindness to another." From these definitions we see that service has to be expressed in deed or it has to be acted out. Before we can perform a kindness to another, there must be someone to show kindness to. In order to give assistance there must be someone who needs assistance. Before we can wait on someone, there must be someone who needs to be waited on. It is, therefore, important to find a place for service and someone who needs to be served. For the nurse this presents no difficulty as all about her are those who need service of one kind or another. She finds ample opportunity to serve.

Service, however, in its truer sense is deeper than to perform duties for someone. It is an ideal. Service means giving people what they need. This may not always be what they want. It may be less than they want or it may be more. To give what people want or demand is different than giving them what they actually need. Children, for instance, may want candy but their parents may be doing them a service by refusing to give it to them. On the other hand, children may not desire education, yet their parents are doing them a real service by providing it for them. For the nurse, then, it is most essential to distinguish between the *needs* of a patient and his *wishes* that may be harmful. To give a diabetic patient a box of chocolates would certainly not be doing him a service. The nurse must have a sound knowledge of the procedures to be followed and must administer them with tact and insight. Service, then, is an expression which combines the idealistic with the practical. Just to have the desire to be of service is of little or no value unless it is evidenced efficiently in graciously given nursing care.

It is also of utmost importance how service is expressed. As the employer wishes the employee to give cheerful service, so in nursing it is equally important for the nurse to show a willingness and eagerness to serve. The nurse must be unselfish which might even include foregoing anticipated pleasures. She must be willing to do the unpleasant things which often require courage and patience. The spirit in which she does all of these things shows whether she is motivated by a real sense of service or whether she serves merely because of the thought of the remuneration she may eventually receive, or even, possibly, punishment if she is neglectful.

True service is no respecter of person. The colored lady in the public ward bed should receive service given in the same spirit as the millionaire's wife who occupies a bed in the most expensive ward. Christ said, "Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto Me."

Neither does true service depend on the greatness or smallness of the deed. A nurse must have a perception of the importance of the smallest things in the comfort of a patient. Again Christ

Miss Rieger is a student nurse at the Misericordia Hospital, Winnipeg, Man.

teaches us that a "cup of cold water given in His name" will be rewarded.

The nurse should always endeavor to serve others as she would wish others to serve those near and dear to her. Her reward will be the respect and confidence of those whom she serves. She herself will experience a deep and lasting inner joy and satisfaction in service.

Book Reviews

Nutrition for Today, by Elizabeth Chant Robertson, M.D., Ph.D. 350 pages. McClelland & Stewart Ltd., 215 Victoria St., Toronto 1. 1951. Price $4.50.

The author hopes that this book will "prove interesting and helpful to many people, including public health nurses, teachers, medical, dental, home economics and social work students as well as housewives and parents." In this she should not be disappointed, as her book is interesting, readable, informative and practical. There are few technical terms, yet information is not lacking regarding essential food factors, experiments showing the effects of food on health and growth, and the composition of available foodstuffs.

Individual chapters are each devoted to one group of foods, as: fruits and vegetables, bread, flour and cereal products, milk and milk products, etc. This makes reference easy and provides comprehensive information about one food group at a time.

The chapter entitled Food Facts and Fancies dispels erroneous ideas about harmful combinations of foods, cooking utensils, food poisoning, and the acid or alkaline effect of foods. It also provides a helpful note on the labelling of foods as sources of vitamins.

Tables (not too complicated) are used generously and with good effect; there is a list of further reading material at the end of each chapter. School lunches are discussed as well as meals for children of different ages. Altogether, this book would prove most helpful to persons cooking for a family or those in a position to give practical information about nutrition through their work. The data are constantly related to foods available and to their cost.

The recipe section, prepared by Mrs. E. Langdon, who conducted the CBC Cooking School of the Air, though short, is a most valuable addition to an already worthwhile book. Each recipe is included primarily because of its nutritional value but flavor, economy and appearance are not forgotten.

Parenthood, by C. Mair Owen, S.R.N. 192 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 1950. Price $1.50.

Reviewed by Ruth Harrison, Public Health Nurse, Uranium, Sask.

This book has been written to try and give to the ordinary parent a comprehensive outline of her physical, mental, and emotional function in producing and rearing a normal infant. As Mrs. Owen states in her preface she has endeavored to avoid writing a too technical, too sentimental, or too lengthy volume but rather has aimed at one that will prove of value to the mother of ordinary understanding and moderate income. Only one who has worked in the industrial area of a great city, over a long period of time, could truly understand the problems which harass the young mother. Questions must be answered such as, "When I first suspect pregnancy where do I go, whom do I see — will I be able to continue working for a while or, even, how do I stop the baby from scratching his face?"

Though certain chapters of this book deal almost solely with the subject of maternity clinics and benefits existing only in the British Isles, the over-all study of the book would give the Canadian mother a comprehensive outline of parenthood from early pregnancy to the time when her child reaches five years of age.

The book could, I believe, be a happy choice of extra reading for the student nurse and would make a useful addition to the library of any school of nursing. The simple way in which the author deals with the anatomy and physiology of the reproductive system and the preparation for labor and confinement would be of great help to the interested student.

The public health nurse, too, dealing as

she does with all sorts of human problems, could find in this work the answers to questions dealing with diet and hygiene of the mother, and similar questions later in regard to the child.

I would not regard this as a textbook but rather as a handbook, full of helpful advice and pleasant reading, to which parents may refer from time to time in answer to questions which arise almost daily during the rearing of a small child.

Handbook for Ward Sisters, by Margaret Scales, S.R.N., S.C.M. 303 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1952. Price $3.35.

Reviewed by Elizabeth Logan, Lecturer, McGill School for Graduate Nurses, Montreal.

A book for ward sisters, or head nurses as they are designated in this country, is a welcome addition to a nursing library. The author of this book has treated the subject in a series of chapters dealing with various aspects of the ward sister's job. The stage is rightly set by first discussing the patient and his needs. By statement or implication the necessity is emphasized for more basic human understanding. This principle is illustrated by reference to specific situations in which the patient is likely to find himself while in the hospital.

The second chapter, entitled The Ward Sister, is probably the key chapter. Here the author gives a general picture of the scope of the ward sister's responsibility and the personal qualities and preparation necessary to meet this responsibility. In this preparation is included a clear definition of what is expected of a ward sister on appointment. Her three major roles are dealt with concisely—as a nurse, a teacher, and an administrator. In describing her first role the author states: "Good nursing requires a knowledge of the individual in the world where he belongs, expresses himself and earns his living; it tries to recognize physical, mental and spiritual needs, to give help so that a patient can maintain health in all these aspects, and to supply care when the different parts of his nature become diseased, tender, or distraught." As a teacher the importance of relations with the student nurse are set forth with understanding. Important principles of administration are stated clearly.

The remaining chapters are devoted to enlarging upon the ward sister's functions with inclusion of specific methods. Particularly helpful should be the chapter entitled Student Nurses and their Training. Though selection of students is not the responsibility of the ward sister, the explanation of criteria used should broaden her general understanding. Other chapters deal with contacts with other hospital personnel and departments, provision and maintenance of the hospital environment, equipment, staffing and assignment, recording and legal aspects.

The stated intention of this book is "to help those embarking on the responsibilities of ward sister for the first time in a school for nurses." The author indicates there is "an apparent widespread need for a restatement of certain principles which, though possibly self-evident, are nevertheless overlooked in the running of a modern ward with its complexity of interests." Most head nurses would find this handbook a helpful guide. Its simplicity and practical approach are useful attributes. Throughout the author has tried to preserve the spirit of nursing in the daily task.

Though the book seems to have local application there is much that is of general interest to ward administrators. Occasionally methods are developed upon assumptions which are still controversial, a fact which in itself provides a need for study. Now, when the task of the ward administrator is under scrutiny, a formulation of the job is timely. Too few books have been written on the subject.

The Education of Nursing Technicians, by Mildred L. Montag, Ed.D., R.N. 146 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1951. Price $2.75.

Reviewed by Mrs. Audrey Galbraith, Instructor of Practical Nursing, Moncton, N.B.

The purpose of this study, as noted in the introduction, is "to propose a program for the training of the nurse with predominantly technical functions, and to set up a program for training nurses for administrative and faculty positions in the above proposed programs."

The author does this very comprehensively. Before doing so she reviews the needs of society for nursing services in order to prove the need for this new type of worker. She also reviews the status of present-day nursing schools. These two chapters represent

a great deal of study and research on the part of the author and present much factual information. The statistics, of course, are those of the United States but conditions are similar in Canada.

It is estimated that two semi-professional or technical workers are required to one professional nurse or in all "about 400,000 by 1960." It is shown here that nursing services may be divided into three main categories:

1. Simple functions requiring a worker with only common knowledge. (This worker may be satisfactorily taught on the job.)
2. Intermediate functions requiring a worker with skill and judgment.
3. Complete functions requiring a worker with expert skill, judgment, and knowledge.

The last named worker would be the professional nurse whom the author feels should receive a higher education than is provided in most nursing schools today. Her training should be in an educational institution and lead to a degree, since "professional" is coming more and more to mean possession of a degree.

The most detailed part of the study, of course, has to do with the education of the worker required in the second category, who is referred to in this study as a "nursing technician." The author declares that the education of this worker also should be carried out in an educational institution. Having Columbia University in mind as the specific institution, she proceeds to outline a course of study. She does not stop here but also outlines a program and course of study for professional nurses preparing to teach this nursing technician.

This study should be of interest to all those interested in nursing education. It should prove very helpful to those interested in setting up programs for teaching nursing assistants, as we call them in Canada, and to those interested in administrative and faculty positions in such programs.

The finest eloquence is that which gets things done; the worst is that which delays.
— DAVID LLOYD GEORGE

As every thread of gold is valuable so is every minute of time.
—*Selected*

British Columbia

The following are staff changes in the British Columbia Division of Public Health Nursing:

Appointments — *Elizabeth Tisdale* (Grace Hosp., Windsor, Ont.) to West Kootenay health unit, Trail; *Margaret Johnson* (Royal Inland Hosp., Kamloops, and University of British Columbia public health nursing course) to North Okanagan health unit, Vernon; *Phyllis Swaisland* (St. Joseph's Hosp., Victoria, and U. B. C. p.h.n. course) to South Okanagan health unit, Kelowna; *Anna Grant* (Vancouver Gen. Hosp.) to Upper Island health unit, Campbell River; *Margaret Strongitharm* (V.G.H. and B.A.Sc., U.B.C.), *Margaret Greig* (Royal Jubilee Hosp., Victoria, and U. B. C. p.h.n. course), *Jessica Field* (Royal Alexandra Hosp., Edmonton, and U. B. C. p.h.n. course) all to Central Vancouver Island health unit, Nanaimo; *Dorothy Donaldson* (V. G. H. and U. B. C. p.h.n. course) to Upper Fraser Valley health unit, Abbotsford; *Norah White* (University of Alberta School of Nursing and B.Sc., University of Alta.) to Central Vancouver Island health unit, Port Alberni; *Mary Caryll* (Bedford County Hosp., Eng., and McGill University p.h.n. course) to East Kootenay health unit, Cranbrook; *Betty Ann Horne* (V. G. H. and B.A.Sc., U. B. C.) to Boundary health unit; *Elaine Thompson* (Winnipeg Gen. Hosp.) to Central Vancouver Island health unit, Nanaimo; *Marie Ford* (Montreal Gen. Hosp. and McGill U. p.h.n. course) to Cariboo health unit, Prince George; *Charlotte Brown* (Regina Grey Nuns' Hosp. and U. B. C. p.h.n. course) to South Central health unit, Lillooet; *Elizabeth Hayward* (V. G. H. and B.A.Sc., U. B. C.) to North Fraser Valley health unit, Mission; *Janet Grieve* (St. Joseph's Hosp., Victoria, and U. B. C. p.h.n. course) to Burns Lake in Cariboo health unit.

After leave of absence to attend U. B. C.: *Betty Dronsfield* to New Denver district of Selkirk health unit; *Beatrice McKinnon* to Keremeos in South Okanagan health unit; *Beryl Lucas* to Hope in Upper Fraser Valley health unit; *Eleanor Bradshaw* to Campbell

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River in Upper Island health unit; *Clara Lysakowski* to Gibsons district; *Elizabeth Ferrie* to Kelowna in South Okanagan health unit; *Peggy MacLean* to Greenwood district of West Kootenay health unit.

Alice Cannon to North Okanagan health unit at Armstrong after leave of absence to take p.h.n. course at Dalhousie University; *Mary Kartner* to Williams Lake in Cariboo health unit after leave of absence to attend McGill University.

Leave of Absence to take the public health nursing course at U. B. C. — *Marilyn Barber* from North Okanagan health unit, *Leola Carr* from Selkirk health unit, *Edith Fisher* and *Shirley Gowe* from Central Vancouver Island health unit, *Elizabeth Hutchinson* from Upper Island health unit, *Phyllis Piddington* from Upper Fraser Valley health unit; *Gertrude Rach* to University of Toronto from South Central health unit; *Letty Watson* from Upper Fraser Valley health unit to McGill University; *Miriam Cressman* from West Kootenay health unit to U. B. C. to complete degree in p.h.n.

Transfers — *Marjorie Craik*, temporarily, to the Division of Tuberculosis Control; *Margaret Whillans* from Upper Island health unit to West Kootenay health unit; *Margaret Goble* from West Kootenay health unit to Upper Island health unit as senior nurse; *Audrey Stephenson* from Upper Island health unit to North Fraser Valley health unit; *Christine Boland* from Simon Fraser health unit to West Kootenay health

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unit; *Frances Gladstone* from Boundary health unit to Simon Fraser health unit; *Frances Stewart* from Upper Island health unit to Grand Forks in West Kootenay health unit; *Helen Byrt* from Fernie to Invermere within East Kootenay health unit; *Phyllis Payton* from Cloverdale to Langley within Boundary health unit; *Irene Stewart* from South Okanagan health unit to East Kootenay health unit; *Shirley Main* from East Kootenay health unit to South Okanagan health unit; *Joan Anderson* from South Okanagan health unit to Peace River health unit; *Marion Boyd* to be senior nurse at Peace River health unit from West Kootenay health unit. *Pauline Siddons* from South Okanagan health unit to open new district of McBride in Cariboo health unit; *Alice Beattie,* supervisor in South Okanagan health unit, has transferred to the same position in Boundary health unit. *Janet Pallister,* after leave of absence to attend course in supervision and administration at McGill University, is now supervisor of South Okanagan health unit.

Resignations — *Marjorie Bannerman* from East Kootenay health unit, *Helen Papple* from Boundary health unit, *Anne Wiens* and *Eileen Hassett* from Cariboo health unit — all to be married; *Doris Brentzen* from Cariboo health unit to accept a position in Clearwater County, Idaho; *Ruth Cresswell* from South Okanagan health unit; *Alison Neilans* from North Fraser Valley health unit; *Isabel Gibson* from Peace River health unit to return to Calgary, Alta.; *Ruby Marsh* from *Selkirk* health unit; *Joan Morison* from Peace River health unit for post-graduate work in the U.S.A.; *Elaine Bradley* from Skeena health unit; *Joyce Young* from Saanich and South V. I. health unit; *Edna Griffiths* from South Central health unit; *Bruna Facchin* from Gibsons public health nursing service to join the Metropolitan Health Committee, Vancouver; *Mary Donald* from Central V.I. health unit; *Esther Netterfield* from Peace River health unit; *Laura Rasmussen* from Central V.I. health unit; *Patricia Blumenauer* from North Okanagan health unit.

Vancouver

The following are changes in the nursing staff of the Metropolitan Health Committee:

Appointments — *Jean Cloarec* (Holy

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Returned to Staff — *Joyce (Read) Camenzind, Isabel Kirkpatrick, Mrs. Elizabeth Metcalfe, Beverley (Chalmers) Revill, Mrs. Grace Robinson.*

Returned from Exchange — *Kathleen Cameron* from a year in Kitchener; *Eileen Ingram* from a year in Birmingham.

Resignations — To be married — *F. Eberts, Grace Pettifor;* to return to home duties — *Mmes Gwen Bowker, Mildred Burton, Frances Carlberg, Eileen Colcleugh, Amelia Evans, Muriel Lorimer, Margaret MacKenzie, Patsy Pickford, Margaret Wood;* to go to other positions — *Jessie McCarthy, Bessie Sherwin.*

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments — *Eleanor (Jamieson) Hurd* (University of Alberta School of Nursing; U. of A. certificate course; B.Sc., advanced course, McGill U.), formerly supervisor; *Frances Alexander* (Toronto Western Hosp. and U. of Toronto general course), *Eleanor Leavens* (Women's College Hosp., Toronto, and U. of T. general

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course), and *Helen (Hickson) Stearns* (Wellesley Hosp., Toronto, and U. of T. gen. course) as director and staff nurses respectively, to Simcoe County health unit; *Kathleen Redgate* (Health visitor and U. of T. advanced course in administration and supervision), *Margaret (Finlayson) Boyle* (Glasgow Royal Infirmary School of Nursing and U. of T. gen. course), *Joan Cormack* (Hosp. for Sick Children, Toronto, and U. of T. gen. course), and *Margaret Stinson* (Ontario Hosp., Whitby, and U. of T. gen. course) as supervisor and staff nurses respectively, to Bruce Co. health unit.

Mary MacIlveen (Victoria Hosp., London, and U. of Western Ontario cert. course), formerly senior public health nurse, North Bay, as supervisor, Peterborough; *Mary Ankcorn* (Owen Sound Gen. & Marine Hosp. and U. of T. gen. course), formerly with Simcoe Co. health unit, to Oshawa; *Ruth Armstrong* (Royal Victoria Hosp., Barrie, and U. of T. gen. course) to Muskoka district health unit; *Joan Astle* (Hamilton Gen. Hosp. and U. of T. gen. course) and *Joyce Nevitt* (Fulham Hosp., Hammersmith, London, Eng., and U. of T. gen. course) to Halton Co. health unit; *Christine Belanger* (T. W. H. and U. of T. gen. course) to Dufferin Co. health unit; *Orlo-Bissillion* (Hamilton Gen. Hosp. and U. of T. gen. course) and *Irene (Vrooman) Gibson* (U. of T. diploma course) to Brant Co. health unit.

Marjorie (Middlebro) Carlisle (T. W. H. and U. of T. gen. course) to Owen Sound board of health; *Catherine Collins* (St. Joseph's Hosp., Toronto, and U. of T. gen. course) and *Helen (Keon) Desjardins* (St. Michael's Hosp., Toronto, and U. of Ottawa cert. course) to Timiskaming health unit; *Elizabeth Cook* (Wellesley Hosp., Toronto, and U. of T. gen. course) and *Barbara Stead* (W. H., Toronto, and U. of T. gen. course) to St. Catharines-Lincoln health unit; *Margaret Coyne* (St. J. H., Toronto, and U. of T. gen. course) to Porcupine health unit; *Lillian Dennis* Royal Victoria Hosp., Montreal, and U. of Ottawa cert. course), *Shirley Gaffney* (Ottawa Civic Hosp. and U.W.O. cert. course), *Agnes (MacPhee) Kelly* (R.V.H. and U. of Ottawa cert. course), and *Mary Sheller* (Chatham Gen. Hosp. and U. of T. gen. course) to Stormont, Dundas and Glengarry health unit; *Daisy Dunlop* (Toronto East Gen. Hosp. and U. of T. gen.

course) and *Dorothy Hodgson* (Hamilton Gen. Hosp. and U. of T. gen. course) to Fort William and district health unit.

Audrey Hannah (Peterborough Civic Hosp. and U. of T. gen. course) and *Marion Taylor* (H. G. H. and U. W. O. cert. course) to Kent Co. health unit; *Lyla Henderson* (Guelph Gen. Hosp. and U. of T. gen. course) to Lennox and Addington health unit; *Elizabeth Kane* (Hotel Dieu, Cornwall, and U. of T. gen. course) and *Nancy Lailey* (W. H., Toronto, and U. of T. gen. course) to Lambton health unit; *Vivian Kenney* (Ottawa Civic Hosp. and U. of T. gen. course) to Prince Edward health unit; *Maria Klimchuk* (St. Paul's Hosp., Saskatoon, and U. of T. gen. course) to Welland and district health unit; *Thérèse Langevin* (Hôp. Ste-Justine, Montreal, and U. of Ottawa cert. course) and *Geraldine Proulx* (Ottawa Gen. Hosp. and U. of O. cert. course) to Prescott and Russell health unit; *Margaret Langtry* (Ottawa Civic Hosp. and U. of T. gen. course) and *Hilda Pletch* (Stratford Gen. Hosp. and U. W. O. cert. course) to Huron Co. health unit; *Doris McGlashon* (Brockville Gen. Hosp. and U. of T. gen. course) to Kenora-Keewatin-Dryden area health unit; *Florence McKay* (T. W. H. and U. W. O. cert. course) to Etobicoke Township board of health; *Elizabeth (Abernethy) Mullin* (Soldiers' Memorial Hosp., Orillia, and U. of T. gen. course) to Windsor Dept. of Health.

Grace O'Leary (St. Joseph's Hosp., Sudbury, and U. of Ottawa cert. course) to Sudbury board of health; *Geraldine Quantz* (Kingston Gen. Hosp. and U. of T. gen. course), and *Audrey Seifried* (St. Mary's Hosp., Kitchener, and U. of T. gen. course) to Wellington Co. health unit; *Marilyn Riches* (Stratford Gen. Hosp. and U. W. O. cert. course) to Peel Co. health unit; *Marilyn Shaw* (St. J. H., Toronto, and U. of T. gen. course) to Sault Ste. Marie board of health; *Vera Snyder* (H. G. H. and U. of T. gen. course) to Hamilton Dept. of Health.

Resignations — *Margaret MacLachlan* and *Gwendolyn (Cooper) Gould* as director and staff nurse respectively of Simcoe Co. health unit; *Mabel Hoy* as public health nursing director, Windsor Dept. of Health; *Rolande Blais* from North Bay; *Mary Lake* from Elgin-St. Thomas health unit; *Jean Sheppard* from Wellington Co. health unit.

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News Notes

ALBERTA

CALGARY

A regular meeting of Calgary District 3 was held in September at Holy Cross Hospital. Forty members were present. It was reported that a serving tray had been presented to Rae Chittick prior to her departure for Montreal. Introduced by L. Wright, Dr. T. A. Richardson gave an interesting lecture on "The Cerebral Palsy Child." Dr. Richardson was thanked by Mrs. Quaife. Mrs. M. Duthie, assisted by the Sisters, served refreshments at the close of the meeting.

Holy Cross Hospital

The Sisters of the Holy Cross Hospital School of Nursing recently entertained the instructors, preliminary students, and Big Sisters at an afternoon tea. This occasion marked the end of a week of orientation, during which time 37 students have been introduced to the various courses and facilities in the school of nursing.

PINCHER CREEK

A regular meeting of Pincher Creek Chapter was held recently with 16 members present. Permission for a Tag Day in aid of the St. John Ambulance Association was granted by the Town Council. Following the business session, the members were entertained by a film.

MANITOBA

WINNIPEG

The Big Sisters of the Misericordia Hospital School of Nursing welcomed 36 Little Sisters at the end of August when they met the director of nursing and the instructors.

NEW BRUNSWICK

MONCTON

At the first fall meeting of the Moncton Chapter, the president, Mrs. Nash Smith, was in the chair and named delegate to the N.B.A.R.N. annual meeting in Fredericton. A moment of silence was observed in memory of the late Florence Breau, former director of nurses at the Moncton Hospital. Mrs. L. Coldwell was appointed to the registry board and Mrs. R. Steeves to replace F. Eagles as convener for the private nurses. Plans were made for a cooking sale. Mrs. Galbraith was welcomed as a new member.

SAINT JOHN

General Hospital

M. Lee and A. Corkery have joined the O.R. staff. J. Daye has returned from post-graduate work in Montreal and Boston and has been appointed assistant supervisor of the Annex. C. Barr, P. Hartt, and E. Butler are doing general duty at the hospital. E. Sherwood is with the Red Cross Blood

Bank. J. Peterson of the O.P.D. has resigned to be married.

St. Joseph's Hospital

J. Sheppard has resigned from the O.R. and has accepted a position in Sacramento, Calif. E. Keenan and D. Gallant are leaving for there also. J. Lawlor will replace Miss Sheppard. J. Nelson and B. McNamara are at McGill School for Graduate Nurses specializing in psychiatric nursing, G. Shannon in nursing arts. Sr. Constance Marie has been transferred to Holy Family Hospital, Prince Albert, Sask.

ONTARIO

DISTRICT 5

TORONTO

General Hospital

M. (Brittin) O'Brien has moved to Edmonton from Grande Prairie as industrial nurse for B.A. Oil. D. James is on the O.R. staff at New York Hospital. Dorothy Smith and M. Darkes are with Ford's in Windsor. L. Evans is doing general duty at the Cedars of Lebanon Hospital, Los Angeles, M. McPhee general duty in New York. R. Jackson is assistant superintendent of nurses at the Toronto East General Hospital. M. Stinson and T. Richards are at the A.V.Roe plant at Malton. R. (McAuley) Macdonald is with the Toxoid Team, Dept. of Public Health, Toronto. M. Cleland, is taking a course at Western University, London. H. Bryson of the permanent R.C.A.F. has gone to Germany for two years.

St. Michael's Hospital

A. Hart and K. Arbour are on the staff of the General Hospital, Edmonton. At St. Joseph's Hospital, Mt. Clemens, Mich., are: C. Heenan, M. E. LeMoine, R. Wakeford. M. Carty is at Hotel Dieu, Kingston, where Sr. St. Peter is supervisor. C. Watson is with the Iroquois Falls Hospital. B. Hornell is on the staff of the Great Neck (Long Island) Visiting Nurses' Association. She is also working towards her Master's degree with a major in education and a minor in supervision. G. McCool is with the staff of a Hollywood hospital.

The following have completed post-graduate study at the universities indicated: Toronto — Sr. M. Lois, R. M. Ellard, Y. FitzGibbons, B. Kelly, K. McGongle, C. Mowder, J. Tiennett, A. C. Wilde; Ottawa — J. Onwu; St. Louis — M. McGarrell; Seattle College — M. C. Sullivan; Houston, Texas — C. McAuliffe; New York — M. Butler; St. Francis Xavier — P. Morrison.

Women's College Hospital

G. Adams is nursing in a hospital in Fresno, Calif. M. Cotterhill is at Johns Hopkins Hospital for a course in operating room technique. E. Leavens is with the Simcoe County Health Unit and G. Simpson is with the V.O.N. in Toronto. Both took courses at Toronto University last year.

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Miss Cusler and J. Purvis are on the staff of W.C.H. J. Bowlby, A. Clinton, and H. Snider are enrolled at Toronto University for courses in public health and hospital administration.

District 8

Ottawa

General Hospital

Sr. St. Bertrand has returned to O.G.H. after an absence of a year. During this time she attended Toronto University, receiving her diploma in psychiatry, after which she had three months' field work in Hartford, Conn., at the Institute of Living. Sr. St. Bertrand is now in charge of the new psychiatric division under the direction of Dr. C. Stern. B. Kelly will join her staff as clinical instructor after completing her course in clinical supervision.

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District 10

A Bursary Committee has been formed by District 10. To date two bursaries of $100 each have been awarded to student nurses. All applications are examined by the committee, careful consideration being given to each one.

Three hundred dollars was realized through the sale of calendar memberships.

District 12

Kirkland Lake

The first annual meeting of District 12 was held in Kirkland Lake in May with Betty Houston acting as chairman. Altogether there were 52 members attending, some having come over 300 miles to be present.

It was revealed that one of the major problems has been locating and getting nurses to register in Ontario. The cooperation of every registered nurse is requested in this tremendous task. Through appointed councillors (one from each town with a nurses' group), an endeavor has been made to draw isolated groups together and a closer liaison with the executive is being accomplished.

Recruitment of high school students, through public health units and public health nurses, is being handled efficiently. In one school, 96 girls were given guidance talks regarding the nursing profession and the film "Girls in White" was shown.

Plans are already under way for the setting up of a district bursary, apart from the two already functioning from the Kirkland Lake and Porcupine chapters.

Helen McArthur, C.N.A. president, was guest speaker at the banquet. In her usual enthusiastic manner she gave a splendid address entitled "Help us to Help Others — It Might be You." She described the functions of the association and gave pointers to help all nurses, as friends, to ultimately benefit the profession as a whole.

The following slate of officers was elected: Chairman, Betty Houston; vice-chairmen, K. King, L. Kelly; secretary, Mrs. S. Robson; treasurer, M. Rice. Committees: Finance, E. Houston; private duty, D. Downey; institutional nursing, S. Morgan; public

health, J. Couture; membership, Mrs. R. McNulty. Councillors: Kapuskasing, M. Coutts; Hearst, K. Mullen; Matheson, A. Chilvers; Cochrane, D. Dooley; Englehart, Mrs. G. McKay. The representative to *The Canadian Nurse* is M. Zufelt.

The Kirkland Lake Chapter was pleased to present L. Arffman with the bursary for nursing last June. She was chosen by the principal and guidance teacher of the Vocational School for her academic standing and adaptability. A rummage sale was held in the local curling rink recently, the proceeds to help with the Christmas Fund and other expenditures.

B. (Houston) Loosemore, former president of District 12, is now living in Quebec.

PRINCE EDWARD ISLAND

CHARLOTTETOWN

Mrs. W. R. Shaw was elected president of the P.E.I. Hospital Alumnae Association at their 14th annual meeting held recently at the Cundall Home.

The retiring president, Mrs. L. Vatcher, presided and submitted her report in which the work of the year was reviewed. Expressions of good wishes were contained in resolutions marking the departure of K. Williams and F. MacMillan, two active and valued members of the organization, who are leaving for North Carolina.

Other officers elected were: Vice-president, Mrs. K. MacKinnon; secretary, F. MacLean; treasurer, B. Tweedy. Committee conveners: Press, Mrs. N. D. MacLean; visiting, M. Thompson; finance, E. Hume.

Following the meeting refreshments were served by a committee consisting of Mmes MacKinnon, S. Moore, and Miss E. Cole.

QUEBEC

MONTREAL

Royal Victoria Hospital

Several members of the Class of 1943-B met in Montreal on September 19 for a reunion on the occasion of their 10 th anniversary. At a tea held in the nurses' home, the members welcomed as their guests: F. Munroe, M. MacIntosh, M. Burdon, C. V. Barrett, H. Lamont, E. Flanagan, B. Cameron, Mrs. L. Fetherstonhaugh, and other members of the nursing staff. Members of the class present were: Sheila (Mingie) Rutledge, Mary (Mackie) Hill, Doris (MacDonald) Lowry, Elinor (Bemister) Woodburn, Hope (Loane) Gammon, Margaret (MacDonald) Lewis, Nancy (Herring) Buchanan, Pauline (Neville) Balfour, Marjorie (Robinson) Putman, Madeleine (Dauphinee) MacNamara; Betty (Winch) Wilkinson. Other activities of the week-end included a tea given for the group by Mrs. Woodburn.

The fall class of preliminary students was welcomed at a tea on September 1.

L. Beck is assistant head nurse, Ward E. L. Rosevear has joined the staff of the teaching department, and M. McLaughlin is on staff on Ross 2. J. Adams has been appointed superintendent of Harbour View

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Hospital, Sydney Mines, N.S. W. Chute is with the teaching department of the Children's Hospital, Halifax. D. Loane has been named supervisor of the Fredericton branch of the V.O.N. and S. Rymer is with the Order in Smiths Falls, Ont.

Recent visitors have been F. (MacDonald) Stewart, who is on the staff at Victoria Hospital, London, Ont., and P. (Jones) Rawlings, San Francisco.

SHERBROOKE

The Sherbrooke Hospital Alumnae Association completed a successful series of activities for 1952-53. Graduation exercises were held May 6. The alumnae sponsored a dinner and dance in honor of the six graduates.

The staff of the hospital welcomes Leah Henshaw as assistant director of nursing. M. Aldrich and J. Peasley have returned to take positions on the teaching staff, after completion of their course in teaching and supervision at McGill School for Graduate Nurses. M.R. Swanson and M. Dougherty resigned to be married. H. Gill, F. Campbell, and H. Boyle are nursing in Peterborough, Ont., R. Lake and L. Lundeborg in Welland, Ont. Several British nurses have joined the staff.

SASKATCHEWAN

FORT SAN

A summer meeting of Qu'Appelle Valley Chapter was held at the home of Mrs. Dorothy Rudy where a picnic supper was enjoyed overlooking Lake Echo. Mrs. T. Howe gave a splendid report on the S.R.N.A. annual meeting. At a later meeting, Catherine Lynch told of her tour of South America following the I.C.N. Congress.

Mrs. F. Upex received a certificate on completion of a course on the use of the E. & J. resuscitator. The course was sponsored by the Rotary Club of Fort Qu'Appelle.

SASKATOON

The monthly meeting of Saskatoon Chapter was held at the City Hospital's nurses' residence. Regular business was dealt with and a draw was made to decide the winner of a suit of clothes which the chapter raffled during the summer. Dr. Harris, presently interning at the hospital, was the lucky man.

Mmes E.H. Henley and F.W. Rosher attended the sixth annual Conference of Women's Auxiliaries in San Francisco.

City Hospital

The new graduates on staff include: Misses J. Holngren, L. Dezeure, V. Kelton, R. MacFarlane, E. Rea, C. Jones, H. Hardin, G. Javena, J. Nicholson, B. Dunford, O. Husak, D. Westbrook, E. Blacklock. A. Wutzke, S. Billett, M. Burke, M. Whitehouse; Mmes Richart, M. Domes, H. Warkentin, M. Thompson.

St. Paul's Hospital

St. Paul's clinical year was opened with a special talk to the graduate staff by Rev. Stanley Ehman, C.Ss.R. Patients say they experience much greater relief from two new Emerson tank respirators recently installed in the polio department. Some of the recent graduates are improving their knowledge by taking courses at the university.

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General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $285; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

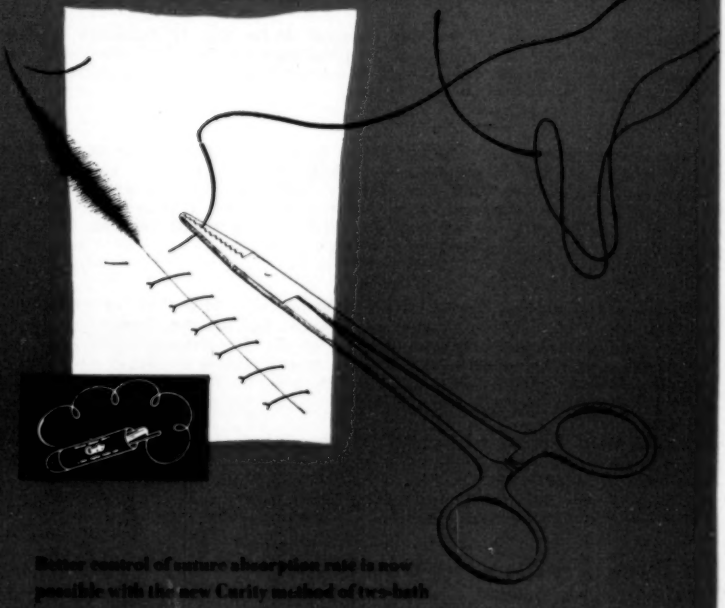
General Duty Nurses for 650-bed Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market, Stockton, California.

General Duty Nurses for 920-bed General Hospital. Starting salary: $190-210 per mo. plus meals & laundry. Credit for past experience, annual increments. 44-hr. wk., rotating shifts. Statutory holidays, 21 days vacation, cumulative sick leave, hospitalization subsidized, pension plan. For further information apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

General Duty Nurses for United Church of Canada hospital, 300 miles north of Vancouver on B.C. coast. Salary: $210 per mo., less $40 for board, room, laundry of uniforms. 2 annual increments of $5.00 per mo. Sick time, 1½ days per mo. cumulative. 1 mo. annual holiday plus 10 days in lieu of statutory holidays. Transportation to Bella Bella refunded after 1 yr. Apply Matron, R. W. Large Memorial Hospital, Bella Bella, B.C.

Curity chromic sutures

are chromicized with two baths for dependable absorption



Better control of suture absorption rate is now possible with the new Curity method of two-bath chromicizing after the strand has been formed. The first bath *does not* "coat" but permeates the strand. The solution used in the second bath combines with the molecules of the first, within the strand, achieving total, even chromicization from rim to center. As a result absorption is similarly uniform. By this method the plies are bonded by their natural mucin.

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SUTURES

THE MONTREAL GENERAL HOSPITAL

The Montreal General Hospital requires:

(1) ***General Staff Nurses.***
(2) ***Operating Room Nurses.***

An interesting variety of experience is available to **Registered Nurses,** both on the Wards and in the Operating Room.

For further information apply to:
The Director of Nursing, The Montreal General Hospital,
60 Dorchester St. East, Montreal 18, Quebec.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $240-270. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses for 200-bed General Hospital in B.C. Interior. Starting salary: $225. Annual increments. Credit for past experience. 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

Graduate Floor Duty Nurses for Mount Hamilton Hospital (Maternity), Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $100. For other perquisites & further information apply Supt.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Registered General Duty Nurses immediately for active 35-bed hospital. Comfortable living accommodation. Salary: $200 with maintenance. 3 wks. vacation after 1 yr. Apply Administrator, Lord Dufferin Hospital, Orangeville, Ont.

Nurses (male & female). Also **Dietitian & Asst. Supt.** Apply, stating qualifications, experience, salary expected, Supt., Lady Minto Hospital, Cochrane, Ont.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Graduate Nurses for 175-bed Tuberculosis Hospital operated by Indian Health Services of Dept. of National Health & Welfare. Hospital situated 7½ miles from Prince Rupert, B.C. (pop. 10,000). Good bus service. Salary: $242 per mo. less $30 per mo. for room, board, laundry. Annual salary increments. 44-hr., 5½-day wk. Regular Civil Service holidays & cumulative sick leave. Apply airmail to Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

Graduate Nurses for 200-bed hospital at Moose Factory, Ont., operated by Dept. of National Health & Welfare, Indian Health Services & serving James Bay & Hudson Bay areas. Hospital is 3 miles from Moosonee which has good rail connections. Salary up to $2,930 per annum minus $30 per mo. for room & board. Good living accommodation, generous leave provisions, plus all other benefits available to public servants. Apply Chief, Personnel Division, Dept. of National Health & Welfare, Booth Bldg., Ottawa, Ont.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Nurse (1) with O.R. experience — salary: $230 per mo. & **General Duty Nurses** for 110-bed hospital. Starting salary: $220 per mo. for B.C. Reg. with annual increase up to $25; less $52.50 for board, room, laundry. 18 days cumulative sick time annually. 28 days vacation after 1 yr. 10 statutory holidays. Excellent golf, swimming, skiing & other recreational facilities. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

Nurses interested in care & rehabilitation of those patients in later years of maturity. Starting salary: $240 per mo. 8-hr. day, 40-hr. wk. 3 wks. vacation. 6 paid holidays. New hospital affiliated with Western Reserve Medical School & associated with University Hospitals. Apply Director, Benjamin Rose Hospital, 2073 Abington Rd., Cleveland 6, Ohio.

Nurses — vacancies for all grades of nurses & other hospital personnel. Apply International Employment Agency, 531 E. Grand Blvd., Detroit 7, Michigan. (Phone WAlnut 1-8543).

General Staff Nurses for mixed services on private & semi-private wards in 378-bed hospital. Residence accommodation if desired. Apply Director of Nursing, General Hospital, Brantford, Ont.

If you are coming to Britain to nurse, you will be welcome at 324-bed Sully Hospital near Penarth, Glamorganshire, South Wales, a modern hospital on the sea. Experience available in Medical & Surgical Nursing of all Chest Diseases in adults & children. Post-graduate course for British Tuberculosis Ass'n Certificate & instruction by medical staff & tutor. Comfortable, modern Nurses' Home with recreational facilities. For further information write H. M. Foreman, M.B.E., M.B., Physician Supt.

WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO

Head Nurse **required for OBSTETRICAL WARD**

Apply, stating qualifications, to:

DIRECTOR OF NURSES, GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

If you are coming to Britain to nurse, you will be welcome at 240-bed Glan Ely Hospital (Pulmonary & Non-Pulmonary), Fairwater, Cardiff, South Wales. **Staff Nurses** (S.R.N.) — excellent experience available in bone & joint surgery & thoracic surgery. British Tuberculosis Ass'n Certificate may be obtained after 12 mos. service. **Student Nurses** for B.T.A. Cert. **Pupil Asst. Nurses** for Training School inaugurated with two local hospitals. All posts resident or non-resident. For further particulars write to Matron.

Matron for Dec. for 36-bed hospital in Southern Interior of B.C. Salary: $290 less $45 maintenance. Statutory & annual holidays as per R.N.A.B.C. Fare refunded after 1 yr. or half after 6 mos. from any point in Canada. Apply, giving full particulars, qualifications, etc., Administrator, Nicola Valley General Hospital, Merritt, B.C.

Supt. of Nurses, Operating Room Nurse & General Duty Nurses (2) for modern, new 23-bed hospital of one-floor construction. Pop. of town — 1,500, 50 miles from Prince Albert & Saskatoon, with exceilent train & bus connections. Gross salary: $270, $225 & $210 per mo. respectively; with three $5.00 increments each 6 mos.; less maintenance, $30 per mo. Apply, stating qualifications & experience, J. L. Fawcett, Sec.-Mgr., Union Hospital, Rosthern, Sask.

Director of Nursing for 150-bed Pulmonary Tuberculosis Hospital with Medical & Surgical Services, located in large eastern city. Must be mature nurse with administrative experience, preferably with post-graduate training — not necessarily in tuberculosis. Salary open. Apply c/o Box D, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Asst. Director of Nursing for 550-bed Teaching Hospital. Degree in Nursing Education required. Liberal personnel policies. Salary: $4,128-5,160. Apply Director of Nursing Service, Medical College of Virginia Hospital, Richmond 19, Virginia.

Nursing Arts Instructor by Dec. for 135-bed hospital — 70 student nurses. For further information apply Director of Nursing, Holy Family Hospital, Prince Albert, Sask.

Supervisors: Operating Room (1), Obstetrical (1), Night (1). Also **Graduate Nurses for General Duty (6).** New 35-bed hospital opening in Nov. Apply Supt., Ajax & Pickering Township General Hospital, Ajax, Ont.

Central Supply Room Supervisor for new 310-bed hospital. Must be R.N. State experience & salary desired. Duties to commence about Jan. 1, 1954. Apply J. B. Caldwell, Chairman, Board of Directors, St. Thomas-Elgin General Hospital, St. Thomas, Ont.

Laboratory Technician (1), Registered Nurses (5) — one with O.R. experience. Also **Grace Maternity Graduates.** Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

DIRECTOR OF NURSES

required for combined position as

Director of Nursing Service and Nursing Education

for

200-bed approved Pediatric Hospital.

Must be qualified by education and experience.

Apply to

The Administrator, The Children's Hospital, Halifax, Nova Scotia.

Registered Nurses for General Duty for new 300-bed General Hospital in downtown Toronto. For information re personnel policies & salaries, apply Personnel Director, New Mount Sinai Hospital, 550 University Ave., Toronto 2, Ont.

Registered Nurses at once for 36-bed hospital in Southern Interior of B.C. Three doctors practising. Active & recreational community. Salary: $225 less $45 maintenance in completely refurnished & redecorated residence. Statutory & annual holidays as per R.N.A.B.C. Fare refunded after 1 yr. or half after 6 mos. from any point in Canada. Apply, giving full particulars, qualifications, etc., Matron, Nicola Valley General Hospital, Merritt, B.C.

Registered Nurses (2) for active 50-bed General Hospital, 100 miles northwest of Toronto. Salary: $155 per mo. plus full maintenance. For further information write or phone Supt., Memorial Hospital, Listowel, Ont.

Nurses for new 30-bed hospital to open in Nov. Apply Matron, Valley Hospital, Box 30, Creston, B.C.

Public Health Nurse for schools. Bilingual. Salary: $2,400-3,000 depending on experience. Apply Clerk, Town Hall, Eastview, Ont.

Operating Room Nurses & Staff Nurses for 170-bed approved hospital with intern staff; half-hour from New York City. Good personnel policies. 40-hr. wk. Beginning salary for operating room nurses: $250. Social Security & Hospital Insurance. Maintenance available at minimum cost. Apply Director of Nursing, General Hospital, Yonkers 2, New York.

Registered Nurses for hospital, 15 miles from Banff. Gross salary: $200 per mo. less $20 maintenance. 40-hr. wk. Cumulative sick leave. 1 mo. holiday after 1 yr. service. Excellent recreational facilities. Apply Matron, Canmore Hospital, Canmore, Alta.

Registered General Duty Nurses (2) for 15-bed hospital. Salary: $175 plus maintenance. $5.00 per mo. increase after 6 mos. service. 3 wks. holiday with pay after 1 yr. Nice town with daily train & bus service east & west. Apply Sec. or Matron, Municipal Hospital, Oyen, Alta.

Graduate Nurses (3) at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alta.

HAMILTON GENERAL HOSPITAL

The **Hamilton General Hospital School of Nursing** invites immediate applications for:

(a) ***Operating Room Dept.*** — Staff and Graduate Floor Duty.
(b) ***Supervisors and Clinical Instructors:***
(i) Medicine. (ii) Surgery.
(c) ***Obstetrical Dept.*** — Staff & Graduate Floor Duty.
(d) ***Head Nurses*** (qualified).
(e) ***Graduate Floor Duty Nurses.***

• General Hospital • 900 beds • 300 students • Opportunities for advancement

For further information write:

Director of Nursing, General Hospital, Hamilton, Ontario

Instructor of Nurses for small Training School. All students have matriculation standing. New nurses' residence with teaching unit to be completed in 1954. Apply Supt., Prince County Hospital, Summerside, P.E.I.

Operating Room Nurse—post-graduate training not essential. All graduate staff. 8-hr. day, 5½-day wk. Apply Director of Nursing, Children's Memorial Hospital, Montreal 25, Que.

Public Health Nurse (qualified) for Peel County Health Unit. Interesting generalized program in rural-urban area near Toronto. Salary schedule: $2,700-3,200. For full details apply Dr. D. G. H. MacDonald, M.O.H., Court House, Brampton, Ont.

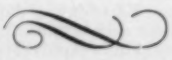
Registered Nurses (2) as soon as possible for new 24-bed hospital under construction. Salary: $210 ($180 net). New nurses' home. Town of 1,500 pop. Apply Mrs. M. E. Locke, Matron, Union Hospital, Eston, Sask.

Graduate Nurse—3:00-11:00 p.m. charge duty & relief Nursing Office. Salary: $225 per mo. plus maintenance. Also **General Duty Nurses.** Salary: $185-200 per mo. plus maintenance. Annual increase. Good personnel practices. 70-bed General Hospital, 25 miles from New York City. Apply Administrator, Tarrytown Hospital, Tarrytown, N.Y.

Registered Nurses (2) immediately for 14-bed General Hospital, Golden, B.C., picturesque town in beautiful Canadian Rockies on main line of C.P.R. Excellent experience offered young graduates. Salary: $220 per mo. less $35 for full maintenance. 44-hr. wk. Fare refunded after 1 yr. service. 28 days holiday per yr. & statutory holidays. Attractive community social life, badminton club, theatre, skating, skiing, curling. Apply Matron.

Strange is our situation here upon earth. Each of us comes for a short visit, not knowing why, yet sometimes seeming to divine a purpose. From the standpoint of daily life, however, there is one thing we do know: that we are here for the sake of others — above all, for those upon whose smile and well-being our own happiness depends, and also for the countless unknown souls with whose fate we are connected by a bond of sympathy. Many times a day I realize how much my own outer and inner life is built upon the labors of my fellow men, both living and dead, and how earnestly I must exert myself in order to give in return as much as I have received.

—Albert Einstein



Emotional Fatigue

Dr. Edward Podolsky, in the June, 1953, issue of *Nursing World*, states that there are many types of fatigue; that it is a normal part of everybody's life; and has a rhythm of its own that rises to peaks daily, weekly, annually and possibly at longer intervals. Fatigue of the mind and of the body are two different things, says Dr. Podolsky. The mind gets tired very easily, while the body has a much greater capacity for activity than is usually suspected.

Emotional fatigue is a condition that affects almost exclusively the ambitious, the spirited, and those who suffer from a sense of duty and drive their minds beyond the limits of safety. Frustration, depression induced by worry, fear and uncertainty regarding the future, anxiety resulting from the assumption of important duties, marital difficulties, financial obligations and social pressures are usually the basis of emotionally-induced tiredness. Emotional fatigue can be differentiated from physical fatigue — it is usually present on awakening, is relieved by breakfast, appears in mid-afternoon, and disappears after dinner. The individual is so tired he hates to get out of bed and there is a definite lack of zest and enthusiasm.

Laboratory examinations reveal that persons suffering from emotional fatigue have a low blood sugar level. Too great an expenditure of emotional energy results in a depression of the blood sugar, with resulting feelings of fatigue.

Emotional hygiene and diet are the two sources of aid that Dr. Podolsky offers to combat this condition. Emotional hygiene consists in the easing of tensions by rest, relaxation and sleep, and the elimination, as far as is possible, of the causes of worry and tension. The diet should be high in proteins, moderately high in fats, and relatively high in carbohydrates. Foods to be avoided are: very fat meat or fish, as sardines, pork, etc., pie, cake, pastry, candy, sugar, jelly, honey, alcoholic beverages, dried peas and beans, onions, radishes. Sugar is not used because it is desirable that the body derive its sugar from the carbohydrates and proteins in the diet, as ordinary sugar disappears from the blood stream rapidly with resultant fatigue. The sugar reduced from the protein and carbohydrate lasts much longer and helps to prevent fatigue.

There is at all times a store of potential energy in the nervous system capable of being released by the proper stimuli. Since an adequate supply of energy is necessary for the smooth functioning of the human body, when there is depletion of this nervous energy a state of nervous fatigue becomes apparent. Fatigue results when recuperative processes of the body are unable to keep the demand for the transformation and output of energy within safe bounds.

Nervous fatigue does not necessarily mean a diminished capacity to *do* work but it does involve a diminished *will* to do work. The mind becomes foggy, simple problems cannot be solved — it is impossible to think clearly. One of the commonest symptoms of emotional fatigue is personality change. There is loss of poise. Difficulty is experienced in getting along with other people. Finesse is lost. Ill manners are frequent.

To get rid of nervous fatigue, there are a few simple measures suggested by Dr. Podolsky:

Obtain at least eight hours' sleep a night to maintain physical fitness and a well balanced personality. The importance of hobbies in this regard cannot be overestimated. Their chief value lies in their capacity to release pent-up nervous tension. The most satisfactory hobbies are those that involve making things with the hands and forming collections one can enjoy.

Rest is a very valuable measure to relieve tension. It is necessary before going to bed to compose one's thoughts, to refrain from alcohol or tobacco, tea, or heavy food, for at least two hours before retiring. Do not take thoughts or worries to bed with you. Dismiss all thoughts from your mind and try to make it a blank. Lie quietly in bed, relax your muscles, and close your eyes. In this state of blankness and relaxation you should find sleep not too long in coming.